Maternal and Child Health Services
Title V Block Grant

State Narrative for Alaska

Application for 2013
Annual Report for 2011

Document Generation Date: Monday, September 24, 2012

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The Commissioner of Health and Social Services signs the Title V application with the required Assurances and
Certifications. These are on file at our office located a 3601 C Street Suite 322, Anchorage, Alaska 99503.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

Since the FY 2011 Block Grant coincides with the 2010 Needs Assessment, a full description of the Title V public
participation program can be found in the 2010 Needs Assessment report. A summary will be presented here.

WCFH, the Title V agency, relies on an on-going, continuous engagement with stakeholders for meaningful public
participation. WCFH-established program advisory committees meet on a regular basis throughout the year. In
addition, all the agencies within the Department of Health and Social Services who offer MCH services, including
WCFH, maintain web pages of their programs. The web sites include contact information.

For the 2010 Needs Assessment, WCFH held a workshop on February 19, 2010. Stakeholder input was obtained by
using a collaborative thinking strategy called the World Café conversation. WCFH also conducted SWOT (Strengths,
Weaknesses, Opportunities and Threats) analyses with several program advisory committees. This included a mini-
summit of the teen advisory group, the Youth Alliance for Healthy Alaskans, on teen pregnancy prevention. Needs
assessments conducted by the Adolescent Health program manager and the School Nurse consultant were
incorporated into the planning process. This included information from a survey of adults and teens in northwestern
Alaska.

Public comments are routinely solicited during community visits by program managers. New

research for this year is
a qualitative analysis of comments from PRAMS surveys. While the analysis was not available for this Needs
Assessment, the data will be very useful to inform future activities in the Perinatal Health program.//2011//

/2012/

WCFH, the Title V agency, relies on an on-going, continuous engagement with stakeholders for meaningful public
participation. WCFH-established program advisory committees meet on a regular basis throughout the year. In
addition, all the agencies within the Department of Health and Social Services who offer MCH services, including
WCFH, maintain web pages of their programs. The web sites include contact information. Program managers again
queried community participants throughout their year to assess how well the MCH/Title V program was supporting
the needs and expectations of the community. Additional input was sought and received through the completion of
the extensive assessment and reassessment conducted in support of the initial grant application for the Maternal
and Early Childhood Home Visiting program and the sequential supplemental applications submitted throughout the
year. //2012//

/2013/
WCFH, the Title V agency again utilized the use of advisory committees comprised of consumers, health care providers and related agencies to assess on an ongoing basis the data supporting our outcome measures and our stated priorites developed from our 2010 Needs assessment. Measurements and priorities are reviewed on a quarterly or every 6th month basis. In addition, the priorities from our needs assessment are assisting us in informing our division strategic plan, a monthly report card (requested by the Chief Medical Officer) and our section reorganization in order to support the Life Course Theory Model as our primary framework. //2013//

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

State priorities for 2010 - 2015 are:

1. Reduce substance abuse among families, including alcohol, tobacco and drugs.
2. Reduce child maltreatment and bullying.
3. Collaborate with families to work toward a system of integrated services for families with infants, children, and teens, and especially those with special health care needs..
4. Reduce the risks associated with unintended pregnancy and teen pregnancy.
5. Reduce dental caries in children 0 - 21 years of age.
6. Reduce intimate partner violence (IPV) including teen dating violence.
7. Reduce preventable post-neonatal mortality due to SIDS/asphyxia.
8. Support communities to increase family and youth resiliency.
9. Reduce the prevalence of obesity and overweight throughout the lifespan.
10. Increase universal screening for post partum depression in women.
11. Strengthen quality school-based health care and health promotion.
12. Implement standardized screening for developmental delay and behavioral health in children 0 - 21 years.
13. Develop capacity to help families navigate the health care system.
14. Acknowledge the importance of men in MCH programs.
15. Reduce late preterm cesarean sections.

In many ways, state priorities have not changed since the 2005 Needs Assessment. Issues of mental health, education, family resiliency and delivery of health care in rural areas are reflected in the state priorities concerning outcomes in substance abuse (#1), child maltreatment (#2), teen pregnancy (#4), intimate partner violence (#6), post-neonatal mortality (#7), chronic conditions (#5, #9), and post partum depression (#10).

New priorities focus on expanding access to services by increasing system efficiency (#3), increasing navigation assistance (#13), and promoting new systems (#11, #13). The State continues to expand implementation of the Early Childhood Comprehensive Systems which supports priorities 1,2, 3, and 8. The ECCS Plan was approved and adopted by the Department of Health and Social Services Commissioner and the Children's Policy Team.

The trend of increasing late preterm cesarean sections, similar to national trends, is an emerging issue (#15). Another emerging issue is incorporating a life course perspective and making the family unit (using very broad definitions of family) to focus on risk and protective factors of the family unit (#14).

The state's MCH program continued to grow in capacity in areas identified as priority in 2005. New programs implemented were the Adolescent Health Program, School Health Program, Perinatal Health Program, and the Pediatric Neurodevelopmental Outreach & Autism Screening Clinic, and the Parent Support Services programs. The Oral Health program has gained two additional staff members in the last five years. The MCH Epidemiology Unit has developed two new surveillance programs and hired additional staff to expand data surveillance and analysis capacity. These programs support priorities 1,3,4, 7, 9 which were carried over from the prior Needs Assessment. The new programs translate to increased ability to pursue grants, expand health education, assess needs, conduct data surveillance and special analysis, conduct program evaluations, and create partnerships.

/2012/ Significant work was expended on developing a Needs Assessment for the Home Visitation program under the Affordable Health Care Act. We analyzed state-wide capacity and needs for home visitation services. The Steering Committee was composed of state agency staff familiar to Title V, and the discussion around home visitation and child welfare will strengthen future collaboration on Title V. A Needs Assessment for CYSHCN was undertaken in February 2011 for the HRSA State Implementation Grant for Systems of Services for CYSHCN grant application.

WCFH will conduct a strategic planning session among its program managers in early Fall 2011 to discuss opportunities to realign its programs and operations with the new priorities. //2012//

//2013// Additional programs and staff were added this last fiscal year to support priorities identified in the needs assessment. An MCH and Pediatric emergency preparedness and disaster planning position was added to respond to the need for more coordinated and specialized planning for vulnerable populations, particularly that of pregnant and postpartum women and children with special health care needs including those with chronic health conditions. This effort will not only support our #3 health priority, but also relates to the 6 national performance measures for children with special health care needs. A environmental scan was initiated in 7 communities this state fiscal year to gain an understanding of needs for emergency preparedness and readiness for events.

In addition, two nurse consultant positions from public health nursing were transferred to WCFH. One nurse consultant position is focused on identifying and implementing evidence based practices to support increases in the immunization rates of children in the state as well as supporting training and quality assurance in public health nursing. In 2012, Alaska was ranked in 42nd place for documentation of completeness of immunizations by 19-24 months. The second nurse consultant position will be a family nurse practitioner who will support the family planning and reproductive health services delivered by the Section of Nursing as well as focus time on early childhood physical and mental health and investigate implementing a nurse consultation program for children in child care settings with an emphasis on those children eligible for Medicaid.

Strategic planning for the Section of WCFH was delayed last year due to changes in the methods required for the department. WCFH will begin to work on their own strategic planning effort early during the state fiscal year 2013. MCH priorities indentified as part of the Title V needs assessment will be incorporated. A framework that applied the life course theory will be applied. In addition, recent opportunities to work collaboratively with chronic disease will be represented in the plan. WCFH is organized around populations and staff work on a variety of programs increasingly working across the populations when targeting priorities. For example activities focused on increasing immunization rates have been identified in all of the unit that represent the populations (women and adolescents, children and children with special health care needs, pregnant women and infants. WCFH staff members will be asked to further identify opportunities to work together on other cross cutting issues such as obesity. WCFH already has two funded programs that represent chronic conditions; oral health and breast and cervical cancer screening so working in programs that are chronic disease focused.//2013//

III. State Overview

A. Overview

Health care delivery

Health care delivery in Alaska consists of three separate systems. The Alaska Native Tribal Health Consortium (ANTHC) is a consortium of tribal entities that provides several levels of medical care: primary care at village clinics, primary and mid-level primary care at regional hospitals, and tertiary care at the Alaska Native Medical Center in Anchorage. ANTHC is funded by the Indian Health Service.

//2013// The two other systems of care include private non-profit and for profit secondary and tertiary care hospitals and private health care providers including nurse practitioners, physician assistants and physicians as well as the expansive military system supporting the active duty and retired armed forces (army, air force and coast guard bases).//2013//

Health care services are very difficult to deliver in rural Alaska due to high transportation costs and lack of skilled resources in the small communities. A number of innovative systems has been created to overcome these barriers. The Community Health Aide Program is a network of about 500 Community Health Aides/Practitioners (CHAPs) who work in village clinics to provide basic health care services and referrals. The CHAP program is a vital link in the Alaska Tribal Health System. The Alaska Dental Health Aide Therapist Initiative, another ANTHC program, is conducted in collaboration with the University of Washington School of Medicine to train Alaska Native dental health technicians for community-level dental disease prevention in underserved Alaska Native populations. The Behavioral Health Aide Project aims to develop village-based behavioral health service capacity, focusing on prevention, early intervention and case management.

Two local governments, the Municipality of Anchorage and the North Slope Borough, operate local health departments with limited services. The State of Alaska, Department of Health and Social Services (DHSS), offers a wide range of health assessment and disease prevention services through 20 public health centers and itinerant nursing services.

Military hospitals and the Veteran's Administration serve the military population. Private sector physicians, health care providers and hospitals can serve any individual in the general population.

Maternal and child health (MCH) programs are managed by different sections within DHSS, Division of Public Health (DPH) and in other divisions within the Department of Health and Social Services. Within DPH, the Section of Women's, Children's and Family Health (WCFH) is the designated Title V agency. WCFH manages the following programs:

- Adolescent Health
- Women's Health
- Breast and Cervical Cancer Screening
- Oral Health (Adult and Child)
- Newborn Metabolic Screening
- Early Hearing and Detection Intervention
- Title X-Family Planning/Reproductive Health
- Genetics and Metabolic Clinics
- Neurodevelopmental Outreach and Autism Screening Clinic
- Family Support Services
- Cleft Lip and Palate Clinics
- Perinatal Health
- School Nursing Consultation and School Health
- MCH Epidemiology

- o Pregnancy Risk Assessment Monitoring Survey (PRAMS)
- o Childhood Understanding Behavior Survey (CUBs)
- o Surveillance of Childhood Abuse and Neglect (Alaska SCAN)
- o Alaska Birth Defects and FASD registry
- o Maternal/Infant/ Child Death Review Committee
- o Maternal -- Child Indicators Program

//2013// In state FY 2012, an MCH and Pediatric Emergency Preparedness and Disaster planning position was added as well as a second position for home visiting and the Perinatal program.. The MCH-Pediatric Emergency Disaster This position will also have some responsibilities over early childhood health. In addition, two nurse consultants were transferred from the Section of Public Health nursing in order to centralize more of the MCH-Child health and Women's health nurse consultants. The MCH epidemiology unit has experienced turnover and retirement of their staff with vacancies in some position for over a year. Ongoing cuts of the MCH Block grant have impacted the ability to maintain a robust epidemiology staff. The Alaska Birth Defects Registry is partially supported with state general funds, and the PRAMS program grant funding is inadequate to cover more than the primary epidemiology position and thus state general funds make up the remainder of the costs associated. The remainder of the unit relies on Title V MCH block grant and SSDI funding. //2013//

The Section of Chronic Disease Prevention and Health Promotion, also within DPH, manages several MCH programs:

- Family Violence and Prevention Project
- Alaska Safe Kids
- Obesity Prevention and Control
- School Health-Youth Risk Behavioral Survey
- Tobacco Prevention and Control

Some MCH programs are managed outside the Division of Public Health:

- EPSDT Outreach - Division of Health Care Services (Medicaid agency)
- Infant Learning/Early Intervention Program - Office of Children's Services
- Early Childhood Comprehensive Systems - Office of Children's Services
- Strengthening Families - Office of Children's Services
- WIC/Nutrition Programs- Division of Public Assistance

At one time these programs were housed within a single MCH section within DPH but were moved to other divisions in the early 2000s during a reorganization of the Department. Attempts to reunite MCH-related programs in the ensuing years were partially successful. The period between 2002 and 2009 was also one of administrative instability, marked by several turnovers at the Commissioner and the DPH division director level. Despite these organizational setbacks, the effort to increase intra-agency collaboration and grow MCH programs continued. These collaborations and ongoing program development continue today.

Principle Characteristics of the State of Alaska

Two defining characteristics of the state are the physical geography and the racial diversity of the population. Alaska is a large, sparsely populated state. The land mass of the state encompasses 571,951 square miles, averaging a population density of just 1.1 persons per square mile. This is the lowest population density of any state.

The 2008 Alaska resident population was estimated at 679,720, with 65% living in urban areas. Seventy percent were reported to be Caucasian alone, 16% Alaska Native/American Indian

alone, 4% Black alone and 4% Hispanic. Twenty percent were reported to be Alaska Native/American Indian alone or in combination with another race category. This is an approximate proportion of the population eligible for ANTHC health services.

Of the people who dwell in rural areas, 82% are Alaska Natives. However, there is a trend of people moving from rural villages to regional centers and urban areas of the state. Looking at it another way, in 2000 58% of the statewide native population lived in rural areas and 42.3% lived in five urban Census Areas: the Municipality of Anchorage, the Matanuska-Susitna Borough, the Kenai Peninsula Borough, the Fairbanks North Star Borough and the City and Borough of Juneau. In other words, Alaska Natives made up 10.4% of the total urban population, double that of 1970 (part of the increase may be due to the fact that in the 2000 Census people were able to identify themselves as Natives of mixed race). It is predicted that the Alaska Native population will be increasingly urban with more than half living in urban areas by 2020.

Alaska is a fairly young state. In 2008 the median age was 33.5 years compared to 36.8 years for the U.S. Alaska Natives residents are even younger, on average than the state as a whole (26.4 years). Residents age 65 or older comprised 7.3% of the population of Alaska compared to 12.6% for the U.S. population. However, Alaska has the fastest-growing senior population in the U.S.

Factors Impacting Health Services Delivery

Approximately 75% of Alaskan communities, including the state's capital city of Juneau, are not connected to the road system. Accessing "nearby health services" or specialized health care means travel by commercial jet, small plane, the state marine ferry system, all terrain vehicles, small boats or snow machines. Some residents may travel distances equivalent to traveling from Washington, D.C. to New Orleans for even routine medical care. Moreover, severe weather can render travel impossible, creating especially critical situations in medical emergencies.

The geographic isolation of rural communities means significant challenges in assuring all MCH populations have access to routine preventive care, acute medical and specialty care. Specialty care, even in urban areas of the state, is limited. For example, the only Level III neonatal intensive care facility is located in Anchorage. Many communities have no facilities equipped for childbirth so pregnant women must leave their homes two weeks before their due date. Even well-child check-ups, prenatal exams and regular dental exams are difficult to provide. Recruiting and retaining physicians and primary health care providers for non-urban practices is also a barrier to providing health care services.

In 2009 the All Alaska Pediatric Partnership, in collaboration with the Alaska State Hospital and Nursing Home Association (ASHNHA) and the Alaska Mental Health Trust Authority (AMHTA), initiated the development of a pediatric subspecialty distribution plan for Alaska. The purpose of this plan was to identify and adopt a distribution strategy that provides the optimal balance of access to care for Alaska's children with an environment that is attractive to new providers, identifies the best use of outside specialists and primary care providers, and ensures volumes necessary to maintain skill sets and provide high-quality, safe care. The Title V Director was a member of the steering committee and the executive committee which had oversight and approval responsibilities. Findings related to service delivery were:

1. There is a growing and diversifying pediatric population and a need for a full range of subspecialty services, but volumes are insufficient to support.
2. Large and difficult geography limits access to subspecialty care, therefore, a reliance on air transport will continue. There are opportunities for telemedicine.
3. While existing resources are better than expected, gaps exist. The gaps can be fill with a coordinated approach of combining in-state and out-of-state resources.
4. No one delivery system can support a full range of subspecialists so collaboration among delivery systems is important.
5. Physician sustainability remains a challenge.

The full report, "Alaska Pediatric Subspecialty Plan" is included as an attachment in Chapter III E.

//2013// The All Alaska Pediatric Partnership actively focused on collaborative recruitment between the Alaska Tribal Health and the Children's Hospital at Providence (TCHAP). These specialists see children statewide and allow for care to be delivered in state. New specialists recruited to Alaska this year included:

- ***A third pediatric hematologist/oncologist (TCHAP-see patients statewide)***
- ***A third and fourth perinatologist (one on each campus)***
- ***Two pediatric endocrinologists (one on each campus)***
- ***A third pediatric surgeon (TCHAP-see patients on both campuses)***
- ***A second full time pediatric nephrologist (TCHAP-sees patients on both campuses)***
- ***New Pediatricians in Anchorage and Fairbanks and Juneau***
- ***New Pediatric psychiatry (North Star Behavioral Health Hospital and Children's Hospital At Providence)***
- ***New Pediatric Emergency medicine specialists (Providence Alaska Medical Center) //2013//***

Disparities

The largest differences in health trend status are between the native and non-native populations and between rural and urban populations. The majority of people living in rural areas are Alaska Native people. The health status of Alaska Native people is poorer than that of non-Native people in several domains. Living in remote communities with high unemployment rates, low income and high barriers to accessing health care services are contributing factors.

Significant improvements in health of Alaska Native people have been made since the 1970s. Large investments in infrastructure such as housing, safe water and sanitation facilities, village health clinics and regional hospitals contributed to significant improvements in life expectancy, infant mortality and infectious disease. However, research documents that continuing and significant disparities remain.

Compared to the non-Native population, the Alaska Native population has poorer health outcomes in post-neonatal mortality; child, adolescent, teen (especially teen suicide), and female mortality; and childhood dental caries experience (among third graders). As the Alaska Native population becomes increasingly urban or adopts western lifestyles and diet, whether by choice or not, chronic diseases such as diabetes and heart disease are of increasing concern.

Cultural diversity among the non-Native population is increasing. About half the students in the Anchorage School District are ethnic minorities and they speak 94 different languages. A culturally diverse workforce that reflects the culture, language and respects the traditions of the populations is a crucial strategy for reducing health disparities.

Health coverage for uninsured women and children is an issue common to all states. Uninsured populations are less likely to access routine, preventive care and more likely to seek care when health problems are severe and require treatment. Lack of preventive health care is a major contributor to poor health status for MCH populations.

State priorities

The overriding theme for future direction for the Alaska Department of Health and Social Services is helping individuals and families create safe, healthy and productive communities. The Department's priorities outlined below span the breadth of the department and encompass the unique service-areas represented within. They include:

• Substance Abuse-Substance abuse affects every family and community in Alaska. It is a contributing factor in suicides, crime, unemployment, domestic violence, child abuse, school dropouts, juvenile delinquency, etc. We need to prevent, intervene early, treat and help people recover from substance abuse through public/private partnerships and long-term strategies;

• Health and Wellness-Many Alaskans lead less happy and less productive lives, and many die prematurely each year, because of disability and death caused by tobacco, alcohol abuse, injuries, obesity, diabetes, cancer, heart disease and sexually transmitted diseases. Most of these outcomes are attributable to personal choice involving diet, physical activity and tobacco use -- and are preventable. We can do a better job of screening, diagnosing and treating these conditions;

• Health Care Reform-Alaska's health care system continues to be fragmented and uncoordinated and doesn't produce the kinds of outcomes we expect. By strategically focusing on care management, reforming Medicaid, creating a Health Care Commission and growing our health-care workforce, we can transform our health-care system;

• Long-Term Care-Seniors represent the fastest growing population in Alaska and it is our responsibility to determine what kinds of services we want for our aging parents (and grandparents) in order to keep them at home in their own communities. We need to develop a long-term care plan, improve services to those with Alzheimer's Disease and related disorders, and promote the expansion of aging and disability resource centers;

• Vulnerable Alaskans-We need to ensure that both kids and communities are safe, that developmentally disabled kids and adults have access to quality services and supports, and that individuals and families get the kind of financial and vocational supports they need to be contributing members of society. By focusing on family-centered services and through the use of performance-based standards and funding, we can better meet the needs of our most vulnerable citizens and their families.

The Title V/CYSHCN program will work to integrate its goals into the department's to assure continuity of services and meet our performance objectives.

/2012/ While overall state priorities have not changed, the short-term focus for the Division of Public Health are: obesity prevention, immunization/infectious disease, strengthening the Medical Examiner's Office, and continuing infrastructure development for the Health Information Exchange and the Electronic Vital Records System. Funding requests for state general funds align with these priorities //2012//

//2013// The Department released its newest health priorities early this state fiscal year. They include:

1. Integrated Health & Wellness

We are focused on improving the health status of all Alaskans. It is necessary to continue bridging both policy and practice gaps that have traditionally existed between primary health care and behavioral health care. We need to prevent, intervene early, treat and help people recover from substance abuse as much as we need to screen, diagnose and treat chronic disease and mental health conditions. We desire to see a healthier Alaska, and believe the following strategies will bring us closer to this reality:•

- ***Promoting prevention and healthy life choices***
- ***Integrating primary care with behavioral health***
- ***Detecting and controlling the spread of infectious diseases***
- ***Promoting diagnostic, treatment and recovery services***
- ***Improving emergency response and preparedness***
- ***Promoting rural infrastructure development***

2. Health Care Access and Delivery

The department is taking steps to improve access to quality health care in Alaska. Alaska Medicaid provides health insurance coverage to approximately 18 percent of Alaska's population. As in other states, Alaska's Medicaid program is challenged to meet increasing costs and demands for services. We believe the following strategies will allow for systemic improvements in both access and service delivery:

- ***Promoting technology for sustainable and effective health care delivery.***
- ***Supporting workforce development***
- ***Enhancing management of high cost health needs***
- ***Improving quality and access of care for underserved populations***
- ***Promoting rural infrastructure development***

3. Sustainable Long-Term Care Delivery System

We are striving to improve long-term care service delivery. Alaska has successfully begun making more services available in homes and communities thereby delaying or avoiding higher cost and more restrictive institutional care for many individuals. There is still work to be done to improve access in rural and remote areas of our state and improve standardization of quality care across the continuum, in order to assure the health and welfare of these citizens. We believe the following strategies are vital to achieving this outcome;•

- ***Identifying and coordinating health and welfare needs***
- ***Promoting a service array that meets the needs of those requiring long-term care services***
- ***Developing an integrated and comprehensive model of care***
- ***Promoting rural infrastructure development***

The Section of WCFH will work in state fiscal year 2013 to reflect its strategic plan one the Division of Public Health as finished their plan. //2013//

The Process to Determine Alaska's Title V MCH Priorities:

Alaska's FY 2010-2015 Title V Needs Assessment was completed in July 2010 by WCFH. Alaska relies on an on-going, continuous engagement with stakeholders to assess MCH needs. WCFH activities revolve around four functions: meeting with WCFH-established advisory committees; participating as a member in other organizations' committees; partnering with other agencies on program implementation; and research.

For the 2010 Needs Assessment, WCFH held a workshop on February 19, 2010. Stakeholder input was obtained by using a collaborative thinking strategy. This technique, called a World Café conversation, was used previously at DHSS in the development of the Early Childhood Comprehensive Systems Program and in WCFH's Safe Infant Sleep Initiative. One hundred seventy invitations were issued to a wide variety of stakeholders across the state; 46 individuals were able to participate.

Three powerful questions were designed to elicit collaborative thinking and deep conversations among very small (3-4) groups of people of different backgrounds and who share a common interest in maternal and child health.

The Needs Assessment Leadership Committee, composed of 10 WCFH program managers and the WCFH Section Chief, met over two months to develop priorities. The themes from the café conversation were primarily process oriented as opposed to program oriented. The Committee decided to use current priorities as a starting point. The following criteria were used to develop new priorities or reconfirm current priorities:

1. Clinical Severity - mortality, years of potential life lost, long term effects, etc.
2. Urgency - comparison to U.S. baseline, and trends
3. Disparities

4. Economic loss
5. Intervention Effectiveness
6. Capacity - within scope of WCFH; community acceptability; legality; availability of state resources
7. Encompasses the life course
8. Known to be protective
9. Identified as a risk factor in Alaska studies

In addition to the café conversation meeting, WCFH conducted SWOT (Strengths, Weaknesses, Opportunities and Threats) analyses with the various program advisory committees supported and led by WCFH.

The Needs Assessment process will be on-going throughout the five-year cycle. The structure is in place to produce updates to the WCFH Fact Sheets that will be shared with the stakeholders from this process, state staff, and made widely available to the public/private health community. The MCH Epidemiology Unit within WCFH produces a biannual Alaska MCH Data Book that is widely distributed throughout the state.

Meetings with stakeholders is also a continuing process in the five-year cycle, with at least one meeting per year to distribute fact sheets, discuss progress on the state priorities and activities, and any current and emerging issues that may impact the state's capacity to address identified issues. Meetings with stakeholders also occur several times a year with each of the WCFH MCH programs' advisory committees.

Current and Emerging Issues

There are numerous issues in MCH that are key in developing Title V strategies, programs and initiatives. These include:

- Workforce development. There is a chronic shortage of pediatric subspecialists. Existing resources are concentrated in Anchorage. Access to these resources from outside the southcentral region entails high transportation costs.
- Chronic conditions in children. While there is no state-wide surveillance of child weight, one-third of children entering kindergarten and first grade in the Anchorage School District were overweight or at-risk for becoming overweight. Tooth decay is currently the most prevalent chronic health issue among children.
- Teen birth. While the teen birth rate of younger teens (15-17) in Alaska is slightly below the national average, the rate among older teens (18-19) is considerably higher than the national average.
- Implementing systems of care and family-centered services. The state seeks to provide an integrated set of early childhood programs through the Early Childhood Comprehensive Systems project. Title V supports this effort to connect state, federal, community, tribal and private provider services that focus on children 0 - 8 years of age.
- Substance abuse. Alaskans continue to experience high rates of substance use. These are risk factors not only for chronic conditions but also for family instability and poor birth outcomes.
- Mental health. Alaska continues to have unacceptably high rates of teen suicide. In addition, child mental health and maternal post partum depression are continuing issues of concern.
- Early intervention. Alaska is increasingly turning its focus on early intervention. Current policies that support early intervention include universal newborn metabolic screening and newborn hearing screening. Early screening for autism and other neurodevelopmental disorders is also a priority. Early intervention can significantly improve a child's outcome for school readiness and general health.
- School health. The increase of chronic conditions among school age children, such as asthma, autism, or diabetes, will require school districts to develop capacity to meet the medical

needs of the children during the school day. Currently the capacity does not exist in the smaller school districts.

• Health insurance coverage for children. Approximately 11% of children in Alaska are not covered by health insurance. In 2008, legislation was passed to restore eligibility in the state's CHIP program to 175% of poverty level. Other tweaks in the Medicaid system, such as allowing expanding the approved enrollment period from 3 to 12 months, can increase coverage. The EPSDT program is an important component of the child immunization program and early intervention efforts.

//2013// Further efforts to restore the level of eligibility to 200% of poverty have been unsuccessful. The legislature passed a bill for the governor's signature in SFY2011, however, it was vetoed based upon the Governor's concern that Medicaid dollars were used to fund abortions. Further attempts by the legislature have failed to reach a compromise with the Governor's office.//2013//

/2012/ Vaccination rates among children have been decreasing. Reversing this trend has become a focus for the Division of Public Health. According to the AK Childhood Understanding Behaviors Survey, 23.8% of families of toddlers have ever delayed or decided not to get immunizations. The most frequently reported reasons given were that the parent thought too many shots are given at once (42%) and that some shots are given too early (35%). The Title V/ CYSCHN Director participates on a Division of Public Health immunization committee tasked to identify and implement strategies to improve the immunization rates for children up to age two. //2012//

/2013/ As outlined earlier in the staffing section, a concentrated effort division wide began in SFY 2012 to focus on raising immunization rates with a particular focus on full immunizations by 2 year of age. Data from the CUBs managed by MCH epidemiology has been used to inform the group regarding potential interventions. The use of the CDC community guide to assist with evidence based practice has been an important handbook. The new Healthy Start program in Norton Sound Regional Corporation (Nome) and the Home visiting program in Anchorage will give an opportunity to do some focused work this next state fiscal year. //2013//

Legislation

FY 2010 - 26th Legislature
In 2009. Governor Parnell put forth an initiative to end domestic violence. The 10-year plan includes a public education campaign in partnership with the Alaska Network on Domestic Violence & Sexual Assault and the Council on Domestic Violence and Sexual Assault; provide meaning law enforcement presence to every community; toughening guidelines for handling sexual assault cases; increase funding for shelters; and coordinating federal, state, tribal and non-profit programs through the Department of Law. Unfortunately, not as much emphasis was placed on primary prevention or secondary prevention, nor was money appropriated for such activities. Nevertheless, WCFH continues to partner and fund primary prevention efforts focused on health relationships and prevention of date rape/intimate partner violence. In addition, the Title V MCH block grant provides substantial funding to support state staff who work to educate health care providers about early screening, intervention efforts and the effects of violence on early brain development.

/2012/ The Governor's Domestic Violence initiative included several approaches: key changes within the criminal justice system, increased enforcement, and raising awareness. Through the leadership of the Governor, many communities held a March Against Domestic Violence and Sexual Assault in March 2011. In February 2011 the state awarded four domestic violence prevention grants for rural Alaska to grantees serving the Bethel, Dillingham, Kodiak and Sitka areas, to be managed by the Division of Behavioral Health. The Adolescent Health manager represents the Division on the Prevention Subcommittee of this task force and the manager for

the Surveillance of Child Abuse and Neglect participates ion the data committee. //2012//

/2013/ WCFH staff members associated with the adolescent health unit have been active in promoting healthy relationships and preventing intimate partner violence in support of the Governor's initiative. This work represents the major framework for the teen pregnancy prevention program funded by the OAH Teen pregnancy prevention grant and the PREP funding, both federally awarded. //2013//

SB 221 established the framework for the Alaska Merit Scholarship program for high school graduates who are Alaska residents to attend a qualified postsecondary institution in the state. The legislation also established a commission to explore funding mechanisms.

Two important bills did not pass. SB 101 would have allowed passive parental consent for the Youth Risk Behavioral Survey. This would have significantly improved response rate. SB 13 would have increased income eligibility for the CHIP program (Denali KidCare) from 175% to 200% of federal poverty level. The bill was vetoed by the governor on grounds that the program covers abortion services. (A 1993 court order requires the state the fund abortions determined medically necessary).

/2012/
FY 2011 - 27th Legislature
The Legislature passed HB 49 to establish a voluntary Parents As Teachers program for preschool children within the Dept. of Education and Early Development. (emailed PAT for current status of legislation. ywg, 7/5) Also passed was an unfunded resolution requesting the Department of Health and Social Services and health care providers to increase attention to vitamin D deficiency and to promote awareness of the potential long-term health benefits of and increased chances of cancer survival with sufficient levels of vitamin D. The Legislature again considered changing parental consent requirement for student participation in surveys from active to passive consent. This did not pass. //2012//

/2013/ Major bills affecting the MCH and /CYSHCN population include the passage of a bill requiring the payment for intensive treatment for children diagnosed with autism spectrum disorders (HB 074). This new law represents a major step in responding to the needs of children diagnosed with this condition and will help to support the systems integration that WCFH has worked on in collaboration with the early intervention programs, the state Autism program (WCFH led), the Family Advisory Council (WCFH led along with Stone Soup-the F2F information center grantee), the Governor's Council on Developmental Disabilities, the University Center for Human Development and LEND program and Providence Autism Diagnostic Network. In addition, a cadre of other state and private agencies and parents have tirelessly advocated for this legislation for the last 10 years. While it will only impact private insurance companies, prior experience has led us to believe that the self insured companies such as the state employee insurance plan and the larger employees will add this as a covered benefit. Of note, this bill was not signed by the Governor, but allowed to go into effect without signature.

Another bill that passed with overwhelming bipartisan support provides for state general funding for three years was HB 310/SB 144, SB that supports the purchase of vaccine and assure universal coverage of most vaccinations for children up to age 21. An attached Epidemiology bulletin outlines the bill specifics and coverage aspects . Over the next year, active work will take place to implement a system similar to that in the state of Washington that provides a floor of funding for universal vaccination coverage and a centralized vaccination depot to maximize the best purchasing price. This model requires insurance company participation as well.

Additional funding for the Parent's as Teachers (HB 49/SB 120) received bipartisan

support, but was significantly reduced by the Governor. Additional bills of public health importance that passed include:

1. Prohibition of texting or dialing while driving (HB 255)

2. Prohibition of the sale or distribution of Cathinone bath salts (HB 253)

3. Support for the expansion of loan repayment for certain health professions in demand in rural parts of the state (HB 272/SB 78))

WCFH provided input into some bills. Testimony during hearings is limited to only the chief medical director and the commissioner, so participation by staff is limited to bill analyses and advising the chief medical officer.

Bills supporting public health priorities that failed to pass include:

1. SB 5 reinstating Medicaid eligibility from 175% to 200%. Failed to move due to the Governor's public stand on preventing the expansion of possible payment using state funds to pay for abortions.
2. HB 61-Advanced Care Registry
3. SB 8-Student Survey's and Questionnaires-this bill would have enacted a active dissent process to conduct YRBS in high schools. //2013//

B. Agency Capacity

Alaska's state health agency, the Department of Health and Social Services (DHSS) has significant capacity to serve women and children from prenatal care and birth through adolescence and adulthood, including health care services for CYSHCN. WCFH is the state's designated Title V agency. There are three critical issues the state faces in providing comprehensive care: geographic isolation, low population density, and shortages in workforce capacity. As mentioned in Part III A, Alaska's health care system differs from other states. There only two locally organized health departments that function under the umbrella agency of the state health department. The key factors in building capacity within the state are the collaborations and partnerships among state agencies as well as between the state and the private sector, tribal entities, the non-profit sector, local communities, other public agencies, and families. Coordination of health components and coordination of health services at the community level occurs through a mix of technical training, partnerships and direct grants to local providers.

Capacity to provide preventive and primary care services for MCH populations and
State support for communities

Community-based services are integral to a comprehensive system of preventive and primary care services for our four primary populations: that of pregnant women and infants, women across the lifespan, children and adolescents, and children/youth with special health care needs. One of the most active community-based health care systems is the Alaska Public Health Centers. The state currently supports Public Health Centers in 23 communities and offers itinerant reproductive health, disease outbreak investigation, and immunization services to remote/frontier communities that do not have a health center. Some of the centers also offer EPSDT exams for children. The Public Health Centers are staffed by Public Health Nurses and the Division of Public Health, Section of Nursing, oversees staffing of the centers. WCFH and the Section of Nursing have long been partners in identifying and providing needed services for the MCH population. For example, family planning service including contraceptive supplies are offered a some of the Public Health Centers made possible with funding by the Title V MCH block grant. Public Health Centers and Public Health Nurses are also the state's frontline providers of initial prenatal care, immunizations, referrals for specialty care, EPSDT services, maternal health

services, etc. Public Health Nursing is frequently contacted when following up with abnormal screens, and lab data. The public health nurses are also critical in many communities to help coordinate the specialty and genetics clinics held in the regional hubs.

The state offers grants to local health care providers and organizations to deliver direct services to women and children. These grants build health care capacity at a local level by supporting local expertise and health care facilities as well as supporting the economic base of small communities with jobs and career options for local populations. Direct grants to local communities are available for Infant Learning Programs, WIC, school-related initiatives, family and community nutrition, breast and cervical cancer screening outreach, reproductive health care and oral health. These locally based efforts are also important to bring culturally competent care to predominately Native communities in remote and frontier areas of the state. For example, the state supports training and education programs, some through the University of Alaska distance delivery or on-campus programs, to educate and train paraprofessionals to deliver WIC, Infant Learning, community health aides, and professional services such as nursing, early childhood teachers and others.

Primary and preventive care to the Alaska Native population at the community level is delivered through village/sub regional clinics and regional hospitals operated by regional non-profit tribal health corporations under the Alaska Native Tribal Health Consortium (ANTHC) umbrella. Individuals qualified to receive services at ANTHC facilities may also choose to use private sector resources. The state assists regional health corporations by collaborating on grants and providing expertise, education and training.

Collaboration with other agencies and organizations

The state's capacity to deliver services to the MCH and CYSCHN populations has been built on the foundation of strong partnerships and collaboration among state agencies, federal programs, the tribal health care system, the private sector, and community-based organizations.

Creating multi-agency advisory committees is one way of establishing and maintaining collaborations. For example, WCFH maintains strong relationships with medical providers and other health care professionals through the NBMS (Newborn Metabolic Screening) Advisory Committee. Issues considered by the committee in the past included hemoglobinapathies, adding cystic fibrosis screening to the screening panel, and implementing tandem mass spectrometry. A sub task force met to improve the mail out and delivery times of the screening cards that are sent from the various birthing hospitals to the state public health lab in Portland, Oregon.

Another excellent example of using partnerships to expand agency capacity is the major role played by the Newborn Hearing Screening Advisory Committee. The Committee initiated the newborn hearing screening program statewide, organized advocates in a six year effort to successfully pass mandatory hearing screening legislation in 2006, and continues to provide input in service delivery and program sustainability, and improving early intervention and treatment options. Capacity has been expanded through partnership with hospitals, birthing centers, and private providers to ensure implementation of the program including follow-up diagnostics and treatment for children who do not pass the initial screens. This newborn screening initiative has been an important and successful partnership between the state, local hospitals, specialty providers and advocacy organizations to provide a comprehensive system of care for children with hearing impairments.

Program management and operations affecting MCH and CYSCHN populations are spread among multiple state agencies in Alaska. An example of interagency collaboration to expand capacity was the effort between the directors of the Division of Health Care Services and the Division of Public Health. They worked collaboratively on issues such as transportation to medical appointments for children (a big expense in the Medicaid budget due to lack of access in

many rural villages); recruitment of sub specialists to meet the needs of children who are Medicaid beneficiaries and who require specialized care not available in the state; and a quality improvement project on timely discharge for medically fragile children from the Level II and III NICU. These collaborative efforts have greatly enhanced the capacity to meet the needs of children with special health care needs. This last effort also included staff from the Sections of Licensing as well as the Division of Senior and Disability Services, hospital case managers, and private care coordinators.

Successful interagency collaboration has also been key to implementing comprehensive, integrated systems of care. In 2008 an Early Childhood Mental Health (ECMH) cross-systems working group, including the Title V MCH Director, was formed to develop recommendations on mental health services. One of the outcomes was the crosswalk between diagnostic codes for young children, billing requirements, and the use of appropriate service codes to ensure services for young children. This resulted in adoption by regulation of the DSM-III diagnostic codes to support childhood mental health services for payment in the Medicaid system. In addition, the collaboration with Early Comprehensive Care Systems Grant (ECCS) led to piloting a system of developmental screening as part of the ABCD Screening Academy project. Efforts are underway with the Medicaid agency to require in regulation the use of one of two evidence-based developmental screening tools as part of a well child screening evaluation. Work is also in progress in with the Division of Behavioral Health, the Office of Children's Services and the University of Alaska to develop early behavioral health intervention training and curriculum and programs in collaboration with the Early Intervention/Infant Learning programs.

/2013/ Recent work involving interagency partnerships include those supporting the requirements that are a part of the Maternal, Infant and Early Childhood Home visiting program, choosing a model program to implement and the community of implementation. Parents employed by Stone Soup and those working as advocate also come together from a variety of locations and agencies to form the Family Advisory Committee. This has provided a forum to discuss issues identified across the state and ensure collaboration with the Family to Family Centers. They current focus is on working to improve emergency preparedness systems that are required to support families with children who are special needs or chronic conditions.//2013//

These summarize WCFH's ongoing relationships with state health agencies:

- Title V programs including Adolescent Health, Women's Health, Perinatal Health, School Nursing Consultation and School Health, Breast and Cervical Health Check, Oral Health, Newborn Metabolic Screening, Early Hearing and Detection Screening, Title X Family Planning, Genetics and Metabolic Clinics, Cleft Lip and Palate Clinic, Neurodevelopmental Outreach and Autism Screening Clinic, Family Support Services and the MCH Epidemiology programs are housed within WCFH under the supervision of the Title V Director. The MCH-Epidemiology Unit manages six surveillance programs that provide data for program design and evaluation, research efforts, grant applications, and policy guidance.

/2013/ In FY 2012, two new programs were established; Pediatric and MCH Emergency and Disaster Preparedness and the Maternal, Infant and Early Childhood Home Visiting/Perinatal Health program. In addition, WCFH was awarded its first Healthy Start Grant in support of reducing infant mortality in rural areas of the state.//2013//

- Medical Examiner's Office - provides information for the Maternal Infant Mortality Review/Child Death Review.
- Section of Chronic Disease and Prevention -- WCFH/MCH- Epidemiology Unit provides primary data on nutrition and weight, collected through the PRAMS and CUBS surveillance programs, for the Obesity Prevention and Physical Activity Program.

2012/ CUBS data on reasons for vaccine delay/refusal was provided to the Immunization Program, to address the falling rates of vaccination and to Section of Public Health Nursing for

their Immunization Practice Guideline manuals. //2012//

/2013/ WCFH staff are all engaged in identifying ways their programs can improve vaccination coverage regardless of the age of the clients served or the population that they work with. Alaska ranks 42nd in the nation according to the last National Immunization Survey. While the methodology utilized to collect this data is thought to be problematic in Alaska (requiring parents or primary care givers to recite what is recorded on immunization cards) is it recognized that coverage rates are not where they should be especially in children less than two years of age. Improving immunization rates for all is one of the top two priorities of the Division of Public Health. The Maternal-Child Public Health nurse consultant II now a part of the WCFH Section is co-coordinating the reporting efforts for the division and leading the efforts within the Section to improve these rates. In addition, WCFH is working on efforts to affect obesity by focusing on improving pregnancy weight using the Institute of Medicine guidelines and best practices and increasing breast feeding by assisting hospitals to improve their breast feeding programs with the goal to become a "Baby Friendly Hospital" and establish support programs in communities that encourage sustaining breastfeeding beyond 6 weeks of age. Staff will also utilize the "Business Case forof Breastfeeding" and the CDC Community Guide to inform this work.//2013//

• Bureau of Vital Statistics (BVS) - the WCFH/MCH-Epidemiology Unit has data sharing agreements with BVS that allows the epidemiology staff to link surveillance and Medicaid data for research and analysis.

• ***/2013/ Section of Public Health Nursing -- Family Nurse Practitioner salary support, contraceptives and cervical cancer screening services purchased with MCH Title V block grant funds support reproductive health services provided at the Juneau Public High Schools by Section of Nursing. Technical and professional support is to assure evidenced based practice is utilized for reproductive health is provided by a Title V supported Nurse Consultant II. This same Nurse Consultant II works with the Section of Epidemiology on the Infertility Prevention Project //2013//.*** Public Health Nursing is frequently contacted when following up with abnormal screens for children identified through the EHDI or NBMS programs. Public health nurses act as case coordinators for families referred to the neurodevelopmental, autism outreach, genetics and metabolic clinics.***//2013//***

• ***/2013/Staff members supported by the Title V MCH Block grant who run the Maternal, Infant and Child Death Review teams attend the state mandated Child Fatality Team meetings to learn about causes of child death with index children and participate in conversations related to keeping other children safe in the home. //2013//***

WCFH's ongoing relationships with other state agencies include:

• Division of Health Care Services (CHIP program) - WCFH collaborates with Medicaid/CHIP to expand coverage of vital services for CYSCHN such as payments of OT, PT, Speech-Language and Audiology services to schools that enrolled as providers of Medicaid. WCFH also collaborate on EPSDT outreach.

/2013/ This year, a pediatric care coordination grant was received by HRSA (D-70 State Implementation Grant for Children and Youth with Special Health Care needs). This grant has enabled WCFH to work collaboratively with the Medicaid agency on piloting care coordination in two clinics and will provide information for possible future expansion //2013//

• Office of Children's Services - WCFH participates on the steering committee of the Early Childhood Comprehensive System (ECCS) program and also assists in the implementation and evaluation of the ECCS program. Title V block grant funds are used to support child abuse and neglect prevention efforts. Funds from the HRSA UNHS grant and the Combating Autism grant

support education for early intervention/infant learning providers in rural parts of the state.

• Division of Public Assistance - PRAMS data is supplied to WIC for program guidance. WCFH partners with DPA to combine TANF and Title V funds for reproductive health services in regions of high teen birth rates and high non-marital birth rates. TANF funds are also utilized in healthy relationships education and prevention of intimate partner violence and to purchase contraceptives for three communities with the highest rates of "out of wedlock" births. ***/2013/ TANF funds are also being used to pilot programs with OCS and DJJ to link adolescents with their judges in an effort to influence future planning and success once they transition out of the foster care system.//2013//***

• Division of Juvenile Justice (DJJ)- WCFH is working closely with DJJ to link data for the child maltreatment surveillance system, managed by MCH-Epidemiology Unit.

/2013/ The largest juvenile detention facility is actively a part of the OAH funded Teen pregnancy prevention program led by WCFH adolescent staff members. //2013//

• Intra-agency committees - The Title V Director is a member of several intra-agency, director level committees responsible for health policy. These include:

o Strengthening Families (SF) Leadership Team. The team, focused on strategies to reduce child abuse and neglect, continues to work towards embedding this framework in state policies and systems.

o The Children's Policy Team, led by the DHSS Commissioner. The team convenes semi-monthly with senior division executives and their staff to report on a number of children's issues and plans for resolution. Standing agenda items include behavioral health improvements in-state for adolescents, particularly in the area of residential treatment centers, progress on autism initiatives, early mental health services for children ages 0-8, and development of systems of care models with a goal towards collaboration among all the divisions having responsibilities for child outcomes.

/2013/This committee was disbanded mid fiscal year by the new Deputy Commissioner. The work was felt to be conducted at the Director level. //2013//

o The Early Childhood Comprehensive Systems (ECCS) Steering Committee. The Title V Director, the epidemiologist for MCH Indicators (from the MCH-Epidemiology Unit) and the Family Services managers are active participants on the implementation committees. The Title V Director represents the Division of Public Health on the interdepartmental ECCS committee chaired by the Commissioner of the Department.

Regional collaborations have also been useful. The Title V/CYSHCN director, newborn screening coordinator, and genetic counselor participated in the implementation of the Western States Genetic Services Collaborative, a regional project focused on expansion of genetics services, education and collaboration among states. The collaborative is working on standardization of data collection to achieve comparability of data across states.

WCFH collaborates with entities within the Alaska Native Tribal Health Consortium (ANTHC) in numerous venues such as co-sponsorship of conferences, assisting with development of grant applications by regional tribal health non-profit agencies, sharing research and data with the Native EpiCenter, and having tribal involvement on WCFH program advisory committees.

/2013/The Title V director was invited to participate on the steering committee for the Maternal, Infant and Early Childhood home visiting program funded in part by one of the tribal MIECHV grants//2013//

WCFH collaborates with other public and private organizations in the following manner:

• WCFH staff works with providers from Seattle Children's Hospital and Medical Center, funded by MCH Title V grants, to hold genetics and metabolic specialty clinics around the state.

• WCFH invites coalitions and non-profit agencies to participate in advisory committees and stakeholder meetings such as the March of Dimes, Planned Parenthood, the Association of Women's Health, Obstetric and Neonatal Nursing, American Academy of Pediatrics-Alaska chapter, Stone Soup Group, , YWCA, and families who participate in Title V programs.

/2013/ WCFH works actively with the Alaska Chapter of ACOG to implement the March of Dimes 39 Weeks campaign to reduce elective non-medical early deliveries prior to 39 weeks.//2013//

• WCFH has a strong relationship with the University of Alaska-Anchorage (UAA) and the University of Alaska-Fairbanks. WCFH staff members are frequent lecturers in the dental hygiene, human services, nursing, child development, laboratory science and MPH programs. The Title V director serves on the advisory program for the UAA's MPH program. The University Affiliated Program at UAA is a close collaborator in developing programs for CYSHCN, especially in the area of transition from adolescents to adulthood. The Title V director is also on the University of Alaska Anchorage committee to develop a doctorate of nursing practice program.
• The Title V/CYSHCN Director and the Children's Health Unit Manager are active participants in the All Alaska Pediatric Partnership, a community coalition of hospitals and medical providers serving the pediatric population of the state.
• The Title V/CYSHCN Director was active in Project Access, a program available in Anchorage for individuals who are underinsured or have no insurance.
• Title V provides funding assistance for post partum depression screening at the Children's Hospital at Providence Hospital.
• WCFH collaborates with the Primary Care Association, a private non-profit organization representing primary care providers , to promote the use of medical homes and expand children's care reproductive health services.

/2012/ Planning for the state Home Visitation program gave us another opportunity to foster collaboration with other DHSS agencies as well as the Dept. of Education and Early Development and Southcentral Foundation. //2012//

State statutes relevant to Title V authority, and impacts upon the Title V program

As of January 2008, Alaska law mandates universal newborn hearing screening for all babies born in Alaska. Currently, Alaska's screening rate for hospital births is about 98% and screening is now performed at all birthing hospitals. Several strategies have been employed to increase screening rates and quality of data including purchase of portable hearing screeners for the smaller communities, disseminating culturally appropriate public education to the general public, providing technical training to direct-entry midwives and Community Health Aide/Practitioners (CHA/Ps - rural Alaskan healthcare providers). An important element of the EHDI program was the acquisition of software for online data input, tracking and follow-up activities, and QA reporting. Data integration with other programs such as NBMS has already been implemented. This will improve the ability to track services offered by MCH programs to all newborns. Potential linkages with other reporting systems include the immunization registry and the Early Intervention/Infant Learning Program.

Also mandated for all newborns are screening tests for PKU and other metabolic disorders that can result in mental retardation and/or other serious health problems. Alaska currently screens for 11 categories (49 disorders) of metabolic and other disorders. Infants and children with positive test results are seen at Title V funded Metabolic and Genetics Clinics for treatment management and genetic counseling. Staffing for the Metabolic Clinic includes a metabolic geneticist specialist, a nutritionist and a genetic counselor. Medical consultation is provided to the local physician caring for the infant or child. The Newborn Screening Advisory Committee, composed of local physicians, laboratory personnel, family members of affected children, midwives and nurse practitioners, provides recommendations for program planning and evaluation.

AS 18.23.010-18.23.070 established the Alaska Maternal Infant Mortality Review (AMIMR) as a medical review organization to retroactively evaluate the circumstances surrounding infant death and make recommendations for reducing Alaska's high infant mortality rate. The AMIMR scope has also been expanded to review fetal and maternal deaths as well. this program has been a major contributor to the dramatic decline of infant mortality during the 1990s. The website link is http://www.epi.alaska.gov/mchepi/mimr/default.stm

/2012/ The Child Death Review (CDR) was re-invigorated approximately three years ago. During the past fiscal year WCFH assisted the MIMR-CDR Committee with data-to-action on winter safety (snow machine and sledding), safe supervision of children at fish camp, and smoke detectors. //2012 //

The Alaska Mental Health Trust was established by the Alaska Mental Health Enabling Act of 1956 during Alaska's transition to statehood. The objective was to transfer mental health services from the federal government to the state. Funding would be provided by prudent management of one million acres of land selected by the state from federal lands. Today, the Trust has established five focus areas for its Comprehensive Integrated Mental Health Program. Recently, the Title V Director collaborated with their "Bring the Kids Home" initiative to provide more in-state residential behavioral health treatment facilities so that adolescents can remain in Alaska for long term treatment. Trust funds are combined with Title V funds for specific programs such as parent navigation services. The Trust's website is http://www.mhtrust.org/index.cfm?section=about-us&page=About-The-Trust

There are a variety of statutes regarding mandatory reporting of health related issues. These include:

- AS 08.64.369 requires health care professionals to report 5 categories of injuries to the Department of Public Safety (DPS):
(1) second or third degree burns to five percent or more of a patient's body;
(2) a burn to a patient's upper respiratory tract or laryngeal edema due to the inhalation of super-heated air;
(3) a bullet wound, powder burn, or other injury apparently caused by the discharge of a firearm;
(4) an injury apparently caused by a knife, axe, or other sharp or pointed instrument, unless the injury was clearly accidental; and
(5) an injury that is likely to cause the death of the patient, unless the injury was clearly accidental.

- AS 47.17 requires 7 categories of professionals to immediately report information to the Office of Children's Services if they have reasonable cause to suspect a child has suffered harm as a result of abuse or neglect. The categories include health practitioners, administrative officers in institutions, employees of domestic violence and sexual assault programs, employees of counseling organizations, law enforcement officers and child care providers.

- 7 AAC 27.012 Physicians, hospitals, and other health care facilities and providers must report children from birth up to 6 years of age who have been diagnosed with or treated for a specific list of birth defects.

- Other health conditions including specific infectious diseases, sexually transmitted diseases, elevated blood lead, cancer, firearm injuries, and diseases caused by toxic substances are also required to be reported. A full list of reportable conditions can be found at http://www.epi.hss.state.ak.us/pubs/conditions/crWhat.htm#birthPhysicians.

In 2007 the state legislature increased the CHIP income eligibility to 175% of poverty level. Inflation had reduced to the eligibility to 150% of poverty level in prior years. The 26th Legislature (2009-2010) passed legislation to increase income eligibility to 200% of poverty level, but the bill was vetoed by the Governor on grounds that the program could cover abortions.

Services for CYSHCN

The inability to access specialty care poses significant challenges for CYSHCN. To address them, a coalition of state and private agencies developed a broader definition of a medical home for Alaska CYSHCN: "The medical home is where a child with special health care needs and his or her family can count on having medical care coordinated by a health care professional they trust. It is not a building, house or hospital, but rather an approach to providing quality and coordinated services". Itinerant public health nurses visit most of Alaska's rural communities providing the "medical home" for many of Alaska's children and families. An R.N., Nurse Practitioner, Community Health Aide or Physician's Assistant provides primary and preventive care in many cases. Primary health care providers and families work as partners to identify and access all of the medical and non-medical services needed to help CYSHCN achieve their potential. Working from this base, a coalition of providers are currently engaged in building a base of specialists and sub-specialists in children's health, holding specialty clinics in rural communities, coordinating specialty care with families either on an itinerant basis or helping families access services in larger communities. As the FQHCs and community health centers before more firmly established, the Title V and CYSHCN staff is working with them on developing greater competency and capacity to care for CYSHCN, adolescents and prenatal women.

Specialty clinics are sponsored throughout the state since these services are not available locally. Multidisciplinary evaluations are conducted at Cleft Lip and Palate (CL/P) Clinics in Anchorage, Bethel and Fairbanks. Children receive consultations at the Autism and Neurodevelopment Clinics in Nome, Kotzebue, Soldotna, Valdez, Barrow, Dillingham, Fairbanks, Juneau and Ketchikan and consultations at Neurology Clinics in Fairbanks. Parent navigation services are offered to assist families to initiate treatment plans, find funding for underinsured or uninsured clients and navigate the health care systems as needed. The paraprofessional navigators are funded through a grant with the Stone Soup Group using Title V funds, general funds, and mental health funds. Parent navigator services are gradually being extended to families with other special needs conditions such as newborn hearing loss, genetics and metabolic conditions. A pilot is being considered with Medicaid services to offer parent navigation for families who have children with chronic health conditions such as diabetes, cancer and asthma in coordination using a nursing case management. The state works closely with The Children's Hospital, Providence Hospital Neurodevelopmental/Autism Center, with referrals to the multidisciplinary team for diagnostic evaluations through the Providence Autism Diagnostic Network. Funding support is provided by the WCFH/Title V agency through a grant using general funds and mental health funds.

Since 2004, the staff of the Division of Health Care Services and the Division of Public Health/WCFH have worked collaboratively on projects to expand capacity such as transportation to medical appointments for children (a big expense in the Medicaid budget due to lack of access in many rural villages); recruitment of subspecialists to meet the needs of children who are Medicaid beneficiaries and who require specialized care not available in the state; and a quality improvement project on timely discharge for medically fragile children from the Level II and III NICU. These collaborative efforts have greatly enhanced the capacity to meet the needs of children with special health care needs. This last effort also included staff from the Sections of Licensing as well as the Division of Senior and Disability Services, hospital case managers, and private care coordinators.

In 2008 the Early Childhood Mental Health (ECMH) working group, including the Title V MCH Director, was formed to develop recommendations on mental health services for young children. One outcome was a crosswalk between diagnostic codes for young children (DSM-III), billing requirements, and the use of appropriate service codes to ensure services for young children. That work was helpful in the development of an Early Comprehensive Care Systems Grant (ECCS) and the collaboration around a pilot program for continuous developmental screening as part of the ABCD Screening Academy project. Work is in progress with the Division of Behavioral

Health, the Office of Children's Services and the University of Alaska to develop early behavioral health intervention training and curricula for the Early Intervention/Infant Learning program.

Ongoing support for the EPSDT program resulted in an expansion of services and payments of OT, PT, Speech-Language and Audiology services to schools that enrolled as providers of Medicaid. Nearly 50% of the children in Alaska are enrolled in the Medicaid program and many have special needs. Enhancing the payment methodology for schools will hopefully provide for increased funding to hire additional needed specialists and provide services for children who qualify for an Individual Education Plan (IEP).

Continuing objectives for the Newborn Metabolic Screening Program are to maintain quality of specimen collection and to reduce hospital discharge refusals. Objectives for the Early Hearing Detection and Intervention are to improve data collection, reduce refusal rates, and increase participation among non-hospital births. These objectives are pursued through targeted educational efforts, training, building strong relationships with providers, and continuous tracking and follow-up. Major efforts were made to implement database linkages between these two programs and with the Early Intervention/Infant Learning Program in order to provide service integration.

/2013/ The Newborn Hearing Screening program (EHDI) has been actively participating in a NICHQ learning collaborative to improve data collection with the military hospitals and increase the number of newborns screening at the birthing centers where deliveries are performed by direct entry midwives. They have been able to demonstrate significant improved outcomes with both efforts.//2013//

In FY2009 the MCH Title V/CYSHCN director was successful in obtaining general funds to provide ongoing support to the Alaska Birth Defects/FASD registry. That program had been entirely funded during the previous four years by the MCH Title V Block grant. In addition, the program now receives over $500,000 in general fund/mental health dollars to support capacity building and expand early identification for children experiencing autism and neurodevelopmental conditions. The new funding source will help assure long term sustainability for programs and system development in support of CYSHCN.

/2012/ WCFH was a successful applicant for the HRSA State Implementation Grant for Systems of Services for CYSHCN. This grant program will improve access to quality, comprehensive, coordinated community-based system of services for CYSHCN and their families, with an emphasis on family-centeredness and culturally competency. This grant will enable the staff who worked on the Autism infrastructure grant to implement enhanced parent navigation systems in support of not only children with neurodevelopmental conditions, but also those with chronic medical conditions //2012//

/2012/ WCFH was a successful applicant for the five-year HRSA State Implementation Grant for Systems of Services for CYSHCN. This grant program will improve access to quality, comprehensive, coordinated community-based system of services for CYSHCN and their families, with an emphasis on family-centeredness and culturally competency. This grant replaces the expired CDC grant that funded our neurodevelopmental/autism outreach program. The program will focus on establishing medical home "model clinic sites" that deliver comprehensive care coordination services for CYSHCN ages 0 - 21, with a special emphasis on the transition from adolescence to adulthood. Care coordination and clinically managed care has been specifically identified by Alaskan families and providers as a fundamentally missing component for successful linkage to effective health care services. It is anticipated that by the end of the project period, June 2014, 80 families will have been served and that at least 10 pediatric or primary care practices will have competency in culturally relevant and evidence based medical home concepts.

This grant program complements Alaska's Medical Home Model Demonstration funded by the

Centers for Medicare and Medicaid (CMS) (Tri-State Child Health Improvement Consortium (T-CHIC)). This demonstration project has three goals : 1) Test federal quality measures of children's care, 2) Promote the use of Health Information Technology (HIT), and 3) Develop medical home approaches for children's care. The project addresses the seven core competencies established by DHSS. //2012//

/2013/ Two long term non-permanent employees were hired and are placed in a community health center in a small rural community 80 miles north of Anchorage and in the pediatric sub-specialty clinic at The Children's Hospital at Providence. Both positions are funded for two and 1/2 years and will focus on developing a care coordination system within the clinic to assure linkages to specialists and primary providers, improve immunization rates, reduce acute emergency visits, improve medication plan adherence, and improve on time well child visits are performed//2013/

Examples of culturally competent approaches:

Applied research conducted by the MCH Epidemiology Unit includes data stratification by Alaska Native status. For example, an analysis of birth certificate data identified 3 new risk factors associated with elevated risk of postneonatal mortality among Alaska Native population. Analysis of the Alaska Birth Defects Registry showed that Alaska Native infants have higher rates, compared to non-Native infants, for 10 of the 15 most commonly identified major congenital anomalies. Collection and analysis of data related to specific congenital anomalies recently led to collaboration with Washington University in Missouri researchers to investigate risk factors for Hirschsprung's Disease. MCH Epidemiology Unit collaborated with CDC and Alaska Native health organizations on a randomized clinical trial to determine the contribution of Helicobacter pylori (Hp) infection to iron deficiency and anemia (prevalence among Alaska Native children and pregnant women are 10-fold higher than other US populations). The results of this study had a direct impact on clinical practice. The Unit is also collaborating with ANTHC's EpiCenter on an Alaska Native health status data book, publication is expected by the end of 2010. /2012/ Publication of the Alaska Native health status data book was postponed to FY2012 (Fall 2011). //2012//

The Youth Alliance for a Healthier Alaska team (YAHA), composed of teens ages 16-19, was formed in 2009 to assist the Adolescent Health program manager design prevention programs around teen pregnancy, healthy relationship promotion and dating violence prevention. A teen summit held in May 2010 included participation of 26 at-risk youths. The input will be used to tailor intervention programs to the culture and attitudes of the local community.

CPT1 (carnitine palmitoyl transferase-1), a condition included in the newborn metabolic screening program, is a metabolic deficiency that occurs more frequently in certain indigenous populations of Alaska and Canada. WCFH created a CD explaining the condition and what parents should do specifically for Alaska Native parents.
http://www.hss.state.ak.us/dph/wcfh/metabolic/downloads/cpt1_brochure.pdf) The Infant Safe Sleep Initiative will be developing culturally appropriate social marketing messages on reducing risks in infant sleep environments. Brochures for the newborn hearing program and the breast and cervical health check programs are targeted to diverse populations.

Two staff members will be receiving MCH /HRSA technical assistance funding for cultural competency work at the statewide MCH Immunization Conference post session in Fall 2010.

C. Organizational Structure

Organizational charts for the Alaska Department of Health and Social Services (DHSS), the Division of Public Health, the Section of Women's, Children's and Family Health, and the Office of Children's Services can be found under Other Supporting Documents. The WCFH Organizational Chart includes positions by program as well as job classification.

Alaska's state health agency, DHSS, is one of 15 departments comprising the Executive Branch of Alaska's state government. The Governor directs the activities of each of these departments through appointed cabinet level commissioners. The DHSS organizational structure is broken down into Divisions with an appointed director to oversee all activities for their Division. The Division of Public Health within the DHSS is charged with primary responsibility for MCH programs. However, two significant programs reside in the Office of Children's Services (Early Intervention/Infant Learning Program) and the Division of Public Assistance (WIC). An organizational chart for the Department is attached.

Alaska differs from most states in that it does not have county health departments that function under the administrative arm of the state health agency. Alaska's health care system is a mix of direct state services, regional and local tribal health care agencies, and private practice health care providers. The state operates local public health centers in 23 communities and offers itinerant public health nursing services for those communities not served by public health centers. The Municipality of Anchorage and the North Slope Borough are the only communities that have locally organized health departments. Federally funded hospitals provide health care services to Alaska's military and Native populations. Additionally, health care services are provided to the Alaska Native population through regional and village health clinics operated Alaska Native Tribal Health Consortium. Other services for MCH populations are provided by non-profit agencies using grant funds from state, federal or other non-governmental funding sources. The state, then, can be involved in providing health care services on numerous levels, as a direct service provider, through grants, or as a partner with Native, federal and private health care organizations in the planning, provision and coordination of health care services.

Currently, the responsibility for some of the state's MCH Title V programs, and the position of Title V and CYSHCN Director, reside in the Division of Public Health. Decisions regarding funding allocations for the Title V grant will be made by the MCH Title V Director with input from the Director of the Division of Public Health and approval from the DHSS Commissioner.

For those programs funded by the Federal-State Block Grant Partnership, the state's administrative role is as follows:

1. Early Intervention/Infant Learning program. This program is located in the Office of Children's Services. The state general funds spent on this program provide a large portion of the state maintenance of efforts to meeet the requirements for Title V. While DHSS is the umbrella organization for both the Title V administrative organization (i.e. the Division of Public Health) and the Office of Children's Services, there will continue to be a coordinated effort to provide information required for the Block Grant application both programmatically as well as fiscally.

2. Women, Infants and Children (WIC) Nutrition program. This program is located in the Division of Public Assistance. There are some state funds that support this program in the form of team nutrition grants, however the bulk of funding comes from the USDA. The WIC program and the other former MCH programs continue to collaborate on activities and participate jointly on statewide committees.

3. MCH surveillance activities. These activities are located in DPH, Section of Women's Children's and Family Health (WCFH).

4. Family Violence Prevention and Childhood Injury Prevention are located in DPH, Section of Chronic Disease Prevention and Health Promotion.

/2013/ Title V dollars have continued to provide financial assistance for this program. //2013//

5. Children's Behavioral Health is located in the Division of Behavioral Health.

/2013/ WCFH collaborates with this division on developing systems of care for children with autism and other behavioral health issues to minimize the number of children transported out of state for residential care. Over the last couple of years larger institutions/health care systems have successfully increased the number of child psychiatrists available in state. In addition, the largest behavioral health hospital has worked in collaboration with the University of Washington to start a Pediatric Psychiatric Fellowship. A bill for state funding did not pass the legislature this year, but was more successful in getting through committees than in years past.//2013//

6. The federal Early Comprehensive Care Systems (ECCS) grant and the Early Intervention Program are located in the Office of Children's Services. The Title V Director and some WCFH staff actively participate in work conducted with the ECCS and Early Intervention program.

7. Primary MCH programs are located in DPH Section of WCFH These include Newborn Metabolic Screening, Newborn Hearing Screening (EHDI), Specialty Clinics, Birth Defects, Metabolic and Genetics Clinics, Neurodevelopmental/Autism Outreach clinic, Oral Health for Children and Adults, Family Planning, Adolescent Health, School Health/School Nursing, and the Breast and Cervical Cancer program and Perinatal and Women's Health.

/2013/ Three new federal grants awarded has led to the implementation of the Maternal, Infant and Early Childhood Home Visiting program, Healthy Start, Health Promotion and Emergency Preparedness for Vulnerable populations, and Pediatric Medical Home coordination.//2013//

The strengthening of interagency working relationships to support MCH programs has been a priority over the last five years.

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Maternal Child Health programs are currently implemented by four divisions within the Department of Health and Social Services: the Division of Public Health, the Office of Children's Services, the Division of Public Assistance, and the Division of Health Care Services. Some of these programs were formerly within the Division of Public Health, however, a major departmental reorganization in 2003 shifted several programs and Title V oversight to other existing or new divisions. In 2005, another smaller scale but significant reorganization returned several MCH programs to a new section (Women's, Children's and Family Health) within the Division of Public Health. From 2003 to 2006 a significant number of positions were eliminated, left vacant, changed position descriptions or experienced turnover.

Division of Public Health-Section of Women's, Children's and Family Health (49 positions):

- Section Chief (Title V/CYSHCN Director) - 1 position.
- MCH Epidemiology Unit:
  - Administrative Support - 1 position;
  - PRAMS -- 2.5 positions;
  - Alaska Birth Defects Registry (ABDR) and FAS Surveillance Project -- 3 positions;
  - Pediatric Physician Epidemiologist - 1 position;
  - Maternal-Infant Mortality Review/Child Death Review Committee -- 1 position;
  - MCH Indicators Surveillance position - 1 position;

- MCH Epidemiologist - 1 position;
- Surveillance of Children who experience Abuse and Neglect -- 1 position;
- Toddler Survey (CUBS)- 2.5 position;
- Public Health Specialist -- 1 position (vacant)
- MCH/HRSA Intern-1.0 position (not counted in Total)

- Women's and Adolescent Health Unit:
  - Administrative Support - 1 position;
  - Breast and Cervical Cancer Screening program -- 7.0 positions;
  - Family Planning -- 1.25 positions;
  - Perinatal Health -- 2.0 position (0.75 Vacant)
  - Reproductive Health Partnership --0.75 position
  - Adolescent Health- 2.0 position (1.0 Vacant);
  - School Nursing Consultation and School Health 1.0 position
  - MCH Disaster Planning-0.25 (Vacant)
  - MCH/HRSA Intern -1.0 position (not counted in total)
- Children's Health Unit:
  - Administrative Support -- 3.0 positions
  - Newborn Hearing Screening -- 1.5 positions
  - Newborn Metabolic Screening -- 1.5 positions
  - Genetics and Birth Defects Program -- 1.5 positions (one is contracted)
  - Autism: 1.25 positions
  - Pediatric Specialty Clinics and Family Support Services -- .75 positions
  - Oral Health - 3.0 positions (1 in Juneau and 2.0 in Anchorage)
- Section Administrative Support:
  - Administrative Assistant II: 1 position
  - Office Assistant III: 1 position
  - Office Assistant I: 1 positions
  - Accounting Clerk: 1 position

Section of Chronic Disease and Prevention:
- Alaska Family Violence Project - 2 positions (financial Support provided by MCH Title V Block grant)
- Child Injury Program - 1 position.

Office of Children's Services:
- Early Childhood Comprehensive Systems Program - 1 position (financial support provided by MCH Title V Block Grant)
- Early Intervention/Infant Learning Program: 4 positions.

Division of Health Care Services
- EPSDT program - 1.5 (1.0 Vacant)

Division of Behavioral Health:
- Suicide prevention support - .5 positions.

Division of Public Assistance:
- Prevention Services
  - Unit Manager - 1 position
  - Administrative Support - 2 positions
  - Community and Family Nutrition Services - 1 position
  - WIC Nutrition Programs - 10 positions in Anchorage and Juneau

All information technology positions (analyst programmers, web masters, etc.) are centralized under the Division of Finance and Management Services, led by the Assistant Commissioner of DHSS.

WCFH staff members are well qualified to deliver services required by Title V MCH, children with special health care needs, and other grant and special funding streams. Over 16 staff members have a master's in public health and four others have master's degree in administration, education, biostatics, planning or other related fields. Seven staff members have double master's degrees. There are also several health care professionals on staff including a pediatrician, a family nurse practitioner, 4 registered nurses, a medical social worker, a MCH registered dietician, a dentist and a dental hygienist.

The Title V MCH/CSHCN Director, Stephanie Birch, has a double master's degree in maternal child public health and nursing with a concentration as a family nurse practitioner. Prior to joining the Division of Public Health, she worked as a registered staff nurse and clinical director. She was the developer and administrator of the state's only children's hospital. Ms. Birch continues to practice in a community-based nurse practitioner practice that serves a low income neighborhood in Anchorage.

The Deputy Section Chief, Thalia Wood, has a master's in maternal and child public health. Her additional part time as a lab supervisor complements her work as manager of the Newborn Metabolic Screening program.

The Family Support Services manager, Kristine Green, in particular came with first- hand experience having delivered premature twins several years ago. Since that time she has spent 18 years working with parents of children with special health care needs, tobacco cessation programs and behavioral health support services. Prior to her hire with WCFH, she developed parent navigation and care coordinator services at The Children's Hospital at Providence, a postpartum support program and several specialized support programs for families with children experiencing chronic illnesses, such as cancer, cystic fibrosis and juvenile diabetes. She works closely with the Family Voices representative on family leadership development and is assisting to develop a Family Advisory committee for the Title V program.

Dr. Brad Gessner, our staff medical epidemiologist and lead research consultant, is a pediatrician who practices part time at the Anchorage Neighborhood Health Center, a community-based facility serving low income clients. He is also is employed by the Pasteur Institute evaluating vaccination programs. Dr. Gessner's combined experience in clinical practice and research has been extremely useful in designing studies with real-world implications. His research on Alaska MCH issues has been extensively published in peer-reviewed journals. The public health specialists in the MCH Epidemiology Unit have master's degrees in public health with concentrations in biostatistics, epidemiology, and evaluation. A list of publications by the MCH-Epidemiology Unit is attached.

/2012/ The MCH-Epidemiology Unit Manager, Yvonne Goldsmith, holds a Master of Science and a Master of Public Health. Her prior service with the State of Alaska was in natural resource planning and policy development. She is the one of the lead staff working on Title V issues. //2012//

The WCFH program staff has impressively diverse experiences including Peace Corps, Vista, public health nursing in rural Alaska, public health internships in third world countries, community planning, early intervention programs, parent navigation and family service delivery in the tertiary hospital, disability service delivery, laboratory supervision, school nursing, genetic counseling and community health education. Ongoing training plans are a part of the annual evaluation process and staff are encouraged and supported to gain new skills and try new programs as opportunities present themselves. All staff members regardless of their position or degree are offered training stipends for public health conferences or education related to their program.

The current WCFH budget is comprised of 60% federal dollars, 15% receipt support services (fees collected at clinics or for newborn metabolic screening), 25% general fund or specialized

general fund dollars. Funding for WCFH has increased steadily every year, particularly in the area of general fund/mental health dollars designated to expand neurodevelopmental screening, and early autism screening and diagnostic expansion. It is not anticipated that WCFH or the Division of Public Health will experience cuts in spending, however , sections and programs may experience reductions over time as funding becomes stagnant and levels do not support required salary increases or additional costs for infrastructure. As new federal grants opportunities are released, WCFH has been supported to date in submitting applications. The challenge will be in obtaining additional FTE's to support grant requirements in light of a mandate from the current administration that no new positions will be approved.

/2012/
Alaska received a $590.0 for year one funding appropriated and authorized by the Affordable Health Care Act to implement home visitation services. The Governor initially approved our application for year one funding, however, we have been placed on hold for a time awaiting approval to implement the home visiting model, spend the funds and apply for year two funding. Our plan calls for us to implement the Nurse-Family Partnership program in the Municipality of Anchorage for up to 100 families over three to five years. The state plan is under state and federal review at this time. If the plan is approved at the state and federal level, the capacity to provide services to high risk families will be expanded.

At the same time, Federal budget reductions to the Title V program for FFY 2012 and beyond will reduce MCH capacity. WCFH will continue to request general state funds to replace federal block grant dollars, but increases in state funding for the section's budget cannot be guaranteed. Likely reductions in some services will be necessary as the federal grant amounts awarded decrease. //2012//

/2013/ Other qualifications of WCFH staff include public health specialists/epidemiologists in the MCH Epidemiology Unit have master's degrees in public health with concentrations in biostatistics, epidemiology, and evaluation. A list of publications by the MCH-Epidemiology Unit is attached.

Update on staffing:

Some changes this year include the resignation of our pediatrician and the addition of 2 more registered nurses.

Division of Public Health-Section of Women's, Children's and Family Health (50 positions):
- ***Section Chief (Title V/CYSHCN Director) - 1 position.***
- ***MCH Epidemiology Unit :***
  - ***Administrative Support - 1 position;***
  - ***PRAMS -- 2.5 positions;***
  - ***Alaska Birth Defects Registry (ABDR) and FAS Surveillance Project -- 3 positions;***
  - ***Pediatric Physician Epidemiologist - 1 position- Vacant-will likely contract;***
  - ***Maternal-Infant Mortality Review/Child Death Review Committee -- 1 position;***
  - ***MCH Indicators Surveillance position - 1 position;***
  - ***MCH Epidemiologist - 2 positions 1.0 Vacant-unsure about funding for FY 2013;***
  - ***Surveillance of Children who experience Abuse and Neglect -- 1 position;***
  - ***Toddler Survey (CUBS)- 2.5 position;***
  - ***MCH/HRSA Intern-1.0 position (not counted in Total)***

- ***Women's and Adolescent Health Unit:***
  - ***Administrative Support - 1 position;***
  - ***Breast and Cervical Cancer Screening program -- 5.0 positions;***
  - ***Family Planning -- 1.25 positions;***
  - ***Perinatal Health -- 2.0 positions***
  - ***Reproductive Health Partnership/Women's Health --1.75 position***

o Adolescent Health- 3.0 Position (1.0 is a long term non-perm position);
o School Nursing Consultation and School Health 1.0 position
o MCH and Pediatric Emergency Preparedness and Disaster Planning-1.0 position
o MCH/HRSA Intern -1.0 position (not counted in total)

• Children's Health Unit:
o Administrative Support -- 3.0 positions
o Newborn Hearing Screening -- 1.5 positions
o Newborn Metabolic Screening -- 1.5 positions
o Genetics and Birth Defects Program -- 1.5 positions (one is contracted)
o Autism/Pediatric Care coordination/Medical Home: 3.25 positions (2.0 are long term non-perm positions)
o Pediatric Specialty Clinics and Family Support Services -- .75 positions
o Oral Health - 3.0 positions (1 in Juneau and 2.0 in Anchorage)
o Maternal- Child Health for Public Health Nursing-1.0 position

• Section Administrative Support:
o Administrative Assistant II: 1 positions
o Office Assistant III: 1 position
o Office Assistant II 1 positions
o Accounting Clerk: 1 position
o Office Assistant I: Temporary position (not counted in the total)

Section of Chronic Disease and Prevention:
• Alaska Family Violence Project - 2 positions (financial Support provided by MCH Title V Block grant)
• Child Injury Program - 1 position.

Office of Children's Services:
• Early Childhood Comprehensive Systems Program - 1 position
• Early Intervention/Infant Learning Program: 4 positions.

Division of Health Care Services
• EPSDT program - 1.5 (1.0 Vacant)

Division of Behavioral Health:
• Suicide prevention support - 0.5 positions.

Division of Public Assistance:
• Prevention Services
o Unit Manager - 1 position
o Administrative Support - 2 positions
o Community and Family Nutrition Services - 1 position
o WIC Nutrition Programs - 10 positions in Anchorage and Juneau

All information technology positions (analyst programmers, web masters, etc.) are centralized under the Division of Finance and Management Services, led by the Assistant Commissioner of DHSS. //2013//
An attachment is included in this section. IIID - Other MCH Capacity

E. State Agency Coordination

WCFH is grounded in the philosophy that strong partnerships and a collaborative approach are critical for systems development, implementation, service delivery and, ultimately, achieving the mission of the Section. A reorganization of DHSS in 2003 created many changes for the Title V program administration, patterns of work, and relationships with other divisions within DHSS. A

significant amount of effort in the ensuing years was devoted to making the organizational transition, orienting and training new staff, and maintaining services while coping with the new environment. These efforts have paid off in strengthened collaborations, new partnerships, and program efficiencies. Many of the MCH programs and initiatives are multi-agency collaborative efforts

The Children's Policy Team was formed in March 2004 to address children's behavioral health, social service and financing issues that impact several divisions or agencies within DHSS -- ultimately to better serve Alaska's children and families. The department recognizes program and budgetary overlaps. Several divisions within the department often work with the same families on social services issues in different capacities. The objective of the Child's Policy Team is to continually streamline problem-solving processes and project development on issues about children's service delivery. One objective is to collaborate with families to limit the number of state offices and state agency staff that families need to interact with in order to get their needs met. The Team began as a core leadership group within the Deputy Commissioner of Operations' office, that included the Divisions of Behavioral Health, Juvenile Justice and the Office of Children's Services (child protection). It has since expanded department wide and includes select program staff including the Title V director.

A description of partnerships between WCFH and other state agencies with MCH program responsibilities, tribal entities, and other private or non-profit agencies was given in Chapter III B, Agency Capacity.

Below is a recap of relevant organizational relationships, summarized by programs and initiatives:

Office of Children's Services (OCS). This is the state's child welfare agency.

- Early Intervention/Infant Learning program MCH Title V partners with the Early Intervention program to assure children identified with neurodevelopmental delays and disorders are referred for services. Program leaders serve on the steering committees for the autism program and the early hearing detection program. Funding is provided to the Early Intervention program from grants to support similar objectives related to early identification and treatment. WCFH staff also work collaboratively with the Early Intervention program on training for their field grantees. Early Intervention members are encouraged to attend specialty clinic appointments of their clients when they are offered in home communities. Finally, parent navigators hired by the state through a grant with the Stone Soup grantee link with early intervention staff when IFSP's are created and assist families in the navigation of service systems as needed.
- Early Comprehensive Childhood Systems (ECCS) program. The ECCS plan was adopted the by the Children's Policy Team and endorsed by the Commissioner of the Department of Education and Early Development. Title V staff work closely with the ECCS coordinator to implement plan objectives, specifically: to expand developmental screening, to develop a model of care coordination to ensure children with developmental or medical needs will be referred to appropriate services, and to increase the number of eligible children enrolled in a public health insurance program. Website: http://www.hss.state.ak.us/ocs/ECCS/ProgramInfo.htm
- ABCD (Assuring Better Child Development) Screening Academy - WCFH staff participated in the technical assistance provided by a grant and used the knowledge gained from that experience to work with the Medicaid EPSDT program to begin developing policies and practice for comprehensive developmental screening in medical homes during well child visits using evidence-based tools. Training on utilizing these tools for developmental screening in underway with tribal community health aides/providers (CHA/Ps) as part of the Combating Autism work. Regulation changes in the Medicaid program will likely need to occur in the near future.
- Strengthening Families Initiative - this is a multi-agency collaborative effort to expand the model across the state. Participation includes WCFH, representing the Division of Public Health, the Division of Public Assistance child care licensing, OCS, private childcare resource and referral centers, and early intervention programs. Funding for Strengthening Families is provided through the Title V MCH Block Grant. Website: http://hss.state.ak.us/ocs/families/default.htm

Division of Senior and Disability Services (DSDS):

- WCFH and DSDS collaborate on issues regarding medically fragile children such as improving coordinated care for medically fragile children discharged from the state's two main NICU's, and finding medical foster homes in a reasonable amount of time for NICU-discharged infants. A steering committee consisting of staff from the Section of Licensing, Office of Children's Services, Medicaid, NICU nurse managers, Durable Medical Equipment providers (DME), early intervention program and others participated in these quality improvement processes. The process to fulfill application requirements for the Medicaid waiver program was streamlined. This allowed a faster turnaround with discharges from the NICU. Availability of trained medical foster care continues to be an issue.

Division of Juvenile Justice:

- Improving mandatory reporting for statutory rape (referred in state statutes as sexual abuse of a minor I-IV) - WCFH led a collaborative effort with Division of Public Assistance, OCS, and Health Care Services (Medicaid) to provide training developed in part by the WCFH Women's and Adolescent Health units. The training is offered on a semi-regular basis to public health nursing centers and private providers. The Adolescent Health program works closely with the Alaska Parent and Youth Foundation and its "Proud Choices" program which is offered in juvenile detention centers in south central Alaska. This evidence-based curriculum is focused on healthy relationship development and teen pregnancy prevention. Future funding has been applied for with the hope of expanding the number of locations that this curriculum is offered.

Division of Behavioral Health:

- WCFH staff has participated in a Comprehensive Mental Health Systems committee to develop strategies to meet the goal of "bringing the children home" from outside behavioral health treatment facilities. Although the focus on prevention of behavioral health issues in very young children is not present currently, this effort has allowed WCFH staff to have an opportunity to insert information regarding the importance of early diagnosis and intervention during the very yearly years as a means to perhaps prevent a need for intervention in the teen years.
- WCFH staff participated in a workgroup to cross walk the DSM-III behavioral health diagnostic codes geared toward young children with current DSM-IV codes to assist behavioral health specialists in the community who have billing privileges with the Medicaid program.
- Behavior Health staff actively serve on the Autism steering committee. Many of the children in residential treatment outside the state have autism as a co-morbidity and this complicates their ability to return home. Future program efforts will be focused on children with autism who are in transition and/or have significant behavioral health needs.
- The Adolescent Health program works closely with Behavioral Health staff in teen suicide prevention emphasizing the use of the Assets Model as a part of the healthy relationships work and teen leadership development.
- The Alaska Birth Defects and Fetal Alcohol Surveillance program, managed by the MCH Epidemiology Unit within WCFH, provides data analysis and evaluation to the Division's Fetal Alcohol prevention program on the effectiveness of prevention efforts.
  - Article: "Decline in the Birth Prevalence of Fetal Alcohol Syndrome in Alaska". 2/17/2010. http://www.epi.alaska.gov/bulletins/docs/b2010_03.pdf

Division of Public Assistance (DPA):

- TANF funding from DPA is the primary source of support for the WCFH Adolescent Health program. This close partnership has resulted in an expansion of contraceptive and reproductive health training and services offered to regions in the state with the highest rates of teen and out of wedlock pregnancy. The teen pregnancy prevention curriculum, focused on healthy relationship development and pregnancy prevention strategies, is offered in many schools across the state and teen leadership development is supported in many rural communities.
- WCFH staff works with the WIC program in promoting folic acid as a neural tube defect prevention strategy. WCFH recently collaborated on a departmental policy to support breast feeding for state employees.

Federally qualified health centers (FQHC):

- WCFH provides technical assistance on contraception, immunizations, and care standards for prenatal, neonatal and pediatric patients when called upon. State staff will be working this next year to make themselves more available for technical assistance in these areas..
- The Reproductive Health Partnership, a collaboration between WCFH, DPA, and tribal health corporations, provides training for reproductive health services as well as contraceptive supplies to the community health centers. This work is focused in the three areas of the state where the rate of teen and 'out of wedlock' pregnancy are the highest

Division of Public Health: WCFH is a section within the Division of Public Health (DPH). WCFH has daily contact and close working relationships with other sections within DPH including Public Health Nursing, Chronic Disease Prevention & Health Promotion, Epidemiology, the Medical Examiner's Office and the Bureau of Vital Statistics. Each of these sections has supported MCH through data collection and analysis, providing direct health care services, and extending prevention and treatment services for MCH populations. As a result of this work, programs managed outside WCFH have started to include children, children with special needs, teens and young families as new initiatives are developed. Examples include collaborative work and planning in the areas of contraceptive and reproductive health; STD prevention; child safety; maternal, infant, and child death reviews; diabetes; tobacco cessation; obesity prevention; and school health.

Division of Health Care Services (HCS): Several years ago a number of Title V programs were moved to the Division of Health Care Services. At that time, the Title V/ CYSHCN Director established a strong collaboration with the Medicaid staff especially in clinical issues and in the development of regulations affecting MCH. Clinical staff from WCFH worked with Medicaid on provider billing, transportation for CYSHCN requiring care in Anchorage or outside of Alaska, consultation and management of dental treatments, home health care regulations and payments for CYSHCN and pregnant women. Although the Title V programs were transferred back to the Division of Public Health, the collaboration with HCS continues especially in the areas of EPSDT-informing, outreach and quality of well child visits. WCFH works closely with HCS in offering direct services for children with genetics, metabolic developmental/autism disorders and those with cleft lip and palate conditions. WCFH continues to bill Medicaid for those clinic services offered to enrolled children 0-21 years of age.

Health care providers. A strong collaboration between WCFH and health care providers and agencies has been a priority. Working relationships are maintained through advisory committees such as:

- All Alaska Pediatric Partnership (AAPP). Contact with health care practitioners, hospitals, clinics and other health care organizations are maintained through this organization. The focus is on delivering high quality hospital and subspecialty services for children throughout the state. Most recently, WCFH provided funding for a study to improve subspecialty service delivery and provider recruitment. See attached draft executive report, "Alaska Pediatric Subspecialty Distribution Plan", May 2010.
- The Newborn Metabolic and Newborn Hearing Screening program advisory committees have also developed strong working relationships with primary care facilities, federally qualified health centers and health care practitioners throughout the state to promote universal screening for all infants regardless of their place of birth in Alaska.
- Breast and Cervical Health Check program maintains links with family planning and specialty clinics, community-based service providers in both the private sector and the native health sector. Website: http://www.hss.state.ak.us/dph/wcfh/bchc/provider/pro_become.htm
- The Perinatal Advisory Committee has links with providers in the private, non-profit, public and tribal health sectors.
- School Nursing Advisory Committee provides support to school nurses across the state to promote universal application of best practices, advocate for school nursing placement in all

school districts, support disaster planning efforts and assure that quality, evidence based school nursing care is delivered based on best practice and commensurate with the state's Nurse Practice Act.

Grantees. Community level grantees deliver direct services for WIC, Early Intervention, Breast and Cervical Cancer Screening Outreach, and parent navigation services. WCFH staff has supported community efforts to promote and plan for the health of children and families. WCFH has also provided direct help when significant health problems have occurred in communities with limited resources. There will continue to be a commitment to service coordination efforts and to addressing new challenges of coordination in the future in light of the reorganization of MCH-related programs and initiatives. The primary agency that WCFH works with for parent navigation/coordination services is the Stone Soup Group. WCFH funds parent navigation services for the autism diagnostic center, outreach clinics, the early hearing detection program and families who have children with cleft lip and palate conditions.

Other outside partners include the March of Dimes, The Association of Women's Health, Obstetric and Neonatal Nursing, AAP-Alaska chapter, families, and other non-profit organizations, such as Stone Soup Group, Epilepsy program, FACE, and the YWCA.

Finally, WCFH has a strong relationship with the University of Alaska, both the Anchorage (UAA) and Fairbanks (UAF) campuses. WCFH staff are frequent lecturers in the dental hygiene, human services, nursing, child development, laboratory science and MPH programs. The Section Chief serves on the advisory program for the UAA's MPH program in support of the program's development and future credentialing application and the steering committee for the doctorate of nursing practice. In addition the Center for Human Development at UAA, is a close collaborator in developing programs for CSHCN especially in the area of transition from adolescents to adulthood and intensive treatment services for children diagnosed with autism spectrum disorder.

/2012/ WCFH's private and public partnerships with stakeholders concerned with child maltreatment were significantly strengthened through the SCAN program manager's participation in the Alaskan Children's Justice Act Task Force (CJATF). The task force meets four times per year and includes members representing these communities: local law enforcement (especially Anchorage Police Dept. and Alaska State Troopers), criminal justice system (AK Dept. of Corrections, AK Dept. of Law, Office of Public Advocacy, judges, prosecuting and private attorneys, CASA), National Committee for Prevention of Child Abuse Alaska Chapter, tribal health system (child advocates), private health providers, AK Dept of Health & Social Services (WCFH, Div. of Juvenile Justice, Div. of Behavioral Health, Office of Children's Services), advocates for CYSHCN, parents. The SCAN program manager contributed to the work of the Task Force by providing child maltreatment data and a public health perspective.

WCFH's collaborations with other agencies involved in child outcomes, including Southcentral Foundation Tribal Health Corporation, were strengthened through the planning process for the Home Visitation program. //2012//

/2013/ New federal funding streams have led to new partnerships in the community. The Maternal, Infant and Early Childhood home visiting program will be implemented likely by a non-profit home health agency connected with the state's largest health care system in the state and well known for their Perinatal, neonatal and pediatric care. In addition, the state's Title V Director sits on the tribal health grantee, SouthCentral Foundation who is also implementing the same program model. This will allow for collaboration on data collection indicators and comparability across systems. Other opportunities to integrate and share information will be explored over time. The new Health Promotion and Emergency Preparedness for Vulnerable populations will allow for shared funding of a position with the state's Governor's Council for Disabilities and Special Education. The focus on health promotion preventative health care will expand the reach to promote

health of this population and support transition to work. In addition, focused activities to improve emergency preparedness for the pediatric and maternal-child health populations will occur. The Healthy Start grant will enable the Perinatal program to focus activities that impact infant mortality in a positive direction in a very rural/frontier part of the state located in northwest Alaska. Finally the State Implementation Grant for Pediatric Care Coordination is providing opportunity to work on establishing a care coordination position in both a rural community health center located 80 miles north of Anchorage when vaccine hesitancy and naturalistic care methods are a part of the social fabric. The second position has been placed in the pediatric specialty clinic to assist families with children experiencing chronic conditions are successfully linked back to their primary care provider for ongoing and preventative care. Both positions will measure a variety of outcomes including emergency visits, medication adherence, appointment follow through, vaccines and well child visits. //2013//

F. Health Systems Capacity Indicators

Reducing dental caries in children 0-21 years is a state Title V priority. In 2011, 58% of Medicaid-enrolled children age 6-9 years received any dental service, an increase of 36% from 2000, when 42% of the target population received dental services. The State Dental Health Official, based in WCFH, heads the Oral Health Program. He works with the statewide oral health coalition, the Alaska Dental Action Coalitiion, to develop policy recommendations and provide advocacy work. The Oral Health Program includes:

- Community Water Fluoridation - the objective of this program is to improve the public's awareness of community water fluoridation, the delivery of optimal fluoridation in community water systems and improve access to alternative fluoride delivery systems to residents without fluoride in their drinking water system. In 2011, Fairbanks, the second largest city in Alaska, considered a ban on fluoridation. Many smaller communities remain unfluoridated.
- Oral Health Plan - the Plan provides policy makers with baseline data on oral health status and identifies oral health disparities through demographic data. The Plan is a framework for implementation of policy to address identified disparities and help improve the oral health of all Alaskans
- Dental Sealant Program - partners with statewide oral health programs on initiatives to help increase utilization of dental services for high-risk children and youth in Alaska. Alaska's Medicaid program covers oral health preventive services for children age 0 to 21 and includes the application of dental sealants. The Alaska Native Tribal Health Consortium has an active dental sealant program for children and youth who qualify for tribally funded health care services. Access to dental sealants is currently available at federally funded Community Health Centers, Medicaid enrolled oral health providers, dental clinics or itinerant providers in rural communities operated by Tribal health organizations and private dental offices.

Alaska lacks data on the oral health needs of CYSHCN. Parents of CYSHCN have reported dental access issues including finding private dentists accepting Medicaid, long wait times for appointments and difficulties coordinating children's medical care, not seeing the same dentist on subsequent appointments and having to spend the fi rst appointment repeating the child's medical history; and limited general dentists treating children with special health care needs - reliance on pediatric dentists for dental services for adolescents and young adults.

Alaska's dental sealant rate of 52.4% for third-grade children exceeded the Healthy People 2010 goal of 50%. Alaska Native third-graders had a sealant utilization rate of 67.8% - the highest of any racial/ethnic group in the state. However, non-Native racial/ethnic minorities lack the same access to this preventive service as white or Alaska Native children. Sealant utilization was also below 50% for white children reported as enrolled in Medicaid/Denali KidCare.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Five-Year Needs Assessment was completed in FY 2010. State priorities for 2010 - 2015 are:

1. Reduce substance abuse, including alcohol, tobacco and drugs, among families.
2. Reduce child maltreatment and bullying.
3. Collaborate with families and others to work toward a system of integrated services for families with infants, children, and teens, and especially those with special health care needs..
4. Reduce the risks associated with unintended pregnancy and teen pregnancy.
5. Reduce dental caries in children 0 - 21 years of age.
6. Reduce intimate partner violence (IPV) including teen dating violence.
7. Reduce risk factors associated with preventable post-neonatal mortality due to SIDS/asphyxia.
8. Support communities to increase family and youth resiliency.
9. Reduce the prevalence of obesity and overweight throughout the lifespan.
10. Increase universal screening for post partum depression in women.
11. Strengthen quality school-based health care and health promotion.
12. Implement standardized screening for developmental delay and behavioral health in children 0 - 21 years.
13. Develop capacity to help families navigate the health care system.
14. Acknowledge the importance of men in MCH programs.
15. Reduce late preterm cesarean sections

For the most part, state priorities did not change significantly from the 2005 Needs Assessment. Issues of mental health, education, family resiliency and delivery of health care in rural areas are reflected in the state priorities concerning outcomes in substance abuse (#1), child maltreatment (#2), teen pregnancy (#4), intimate partner violence (#6), post-neonatal mortality (#7), chronic conditions (#5, #9), and post partum depression (#10).

New priorities focus on expanding access to services by increasing system efficiency (#3), increasing navigation assistance (#13), and promoting new systems (#11, #13). The State continues to expand implementation of the Early Childhood Comprehensive Systems which supports priorities 1,2, 3, and 8. The ECCS Plan was approved and adopted by the Department of Health and Social Services Commissioner and the Children's Policy Team.

The trend of increasing late preterm cesarean sections, similar to national trends, is an emerging issue (#15). Another emerging issue is incorporating a lifecourse perspective and making the family unit (using very broad definitions of family) to focus on risk and protective factors of the family unit (#14).

Since 2005 the state's MCH program continued to grow in capacity in areas identified as priority in 2005. New programs added include the Adolescent Health Program, School Health Program, Perinatal Health Program, and the Pediatric Neurodevelopmental Outreach & Autism Screening Clinic. Two new surveillance programs were established - the Childhood Understanding Behaviors Survey (CUBS) and the Surveillance of Child Abuse and Neglect (SCAN). The Child Death Review was re-established to examine deaths of children 1-14 years of age.

These programs support state priorities 2, 3, 4, 6, 7, 11, 12, 13 and 15. The new programs translate to increased ability to pursue grants, expand health education, assess needs, and create partnerships.

CUBS is one of the newest surveillance programs, launched in FY 2006, in response to community and staff concerns on early childhood health. It is a PRAMS follow-up survey that

provides population-based data on pre-school aged children in Alaska. The goal is to evaluate the association between prenatal and immediate postnatal factors with early childhood health and welfare. The current survey is of mothers of three year olds. Alaska is only one of four states surveying the health and developmental status of toddlers. The linkage of PRAMS and CUBS provides opportunities to look at longitudinal data. Both surveys include the same questions about maternal mental health to track state performance measure #10, to support universal screening for post partum depression.

To address the state priority of reducing the rate of child abuse and neglect, a new surveillance program, the Alaska Surveillance of Child Abuse and Neglect (Alaska SCAN) was created in 2007. The program resides within the MCH-Epidemiology Unit. The goal is to provide reliable, accurate, and consistent data of child maltreatment through an integrated and centralized data depository. The Alaska SCAN system links data from various organizations which include, but are not limited to, hospital in-patient records, emergency department records, police and homicide reports, child death review findings, and child protect services reports. This systematic collection of information and application of standardized, sensitive public health definitions promotes data consistency over time. Data from SCAN will also be used to implement, monitor, and evaluate scientifically-based, community focused initiatives, as well as advocate for resources based on reliable and consistent information.

The Alaska MIMR has been instrumental in improving health outcomes of infants since the early 90's. The analysis of risk factors associated with SIDS/unexplained asphyxia led to bed-sharing recommendations contrary to those of the American Academy of Pediatrics. The state has implemented a Safe Sleep Initiative to further clarify its recommendations.

/2013/

WCFH provided leadership in adopting the AMCHP/March of Dimes/ ASTHO goal of reducing non medically indicated deliveries prior to 39 weeks. As result we will be revising our state priority number 15 to reflect the goals outlined by their collaborative effort. The local March of Dimes chapter in Alaska has been the primary leader in this effort with the All Alaska Pediatric Partnership providing the forum for its dicussion and organizer of the state's birthing hospitals to adopt the tenets outlined by the initiative. More on this topic is discussed eleswhere in the grant application. //2013//

B. State Priorities

Focus will continue to be on prevention and early intervention services related to family violence, child abuse and neglect, young children's access to health care and reduction of unplanned pregnancy. The MCH Epidemiology Unit has primary responsibility to collect and analyze data, and to conduct evaluation and research activities.

State priorities are as follows (not listed in order of importance):

Priority #1. Reduce substance abuse, including alcohol, tobacco and drugs, among families.

Performance Measures:

- Percent of women (who delivered a live birth) who had one or more alcoholic drinks in an average week during the last 3 months of pregnancy. (state)
- Percent of students who smoked cigarettes on 20 or more days during the 30 days before the survey (state)
- Prenatal smoking (smoking in the last 3 months of pregnancy) is a national performance measure.

Infrastructure Building Services:

- An interdivisional preconception/interconception planning committee was initiated in 2009

to improve women's health during the adolescent years through preconception, prenatal and postpartum time periods. Smoking cessation, alcohol and substance abuse prevention are topics of focus.

- Usage of iq'mik and commercial spit tobacco, popular among the Alaska Native population, is collected through PRAMS.

Population Based Services:

- WCFH staff collaborates with the local March of Dimes chapter on the preterm delivery campaign to develop smoking cessation classes with hospitals and local agencies and to develop support systems for women who are pregnant.
- Programs such as reducing and preventing underage drinking; rural substance abuse prevention; and tobacco enforcement and youth education are managed by the Division of Behavioral Health.
- The Alaska Tobacco Control Alliance operates the free Tobacco Quit Line. WCFH staff provide data and input into public media campaigns and quit line support to include stop smoking cessation messages for pregnant women.

Priority #2. Reduce child maltreatment and bullying.

Performance Measure:

- Rate of reports of maltreatment per thousand children under age 18 years. (state)

Infrastructure Building Services:

- Data sharing agreements are being pursued with partner agencies to fully implement the Surveillance of Child Abuse and Neglect.
- WCFH continues to collaborate with other state agencies: 1) expand Strengthening Families model statewide; 2) implementation and evaluation of the ECCS program; 3) pursue grant opportunities such as Project Launch and home visitation programs.
- WCFH is collaborating with the Office of Children's Services on the ECCS program and is one of two Division of Public Health representatives on the Interdepartmental ECCS committee.

Priority # 3. Collaborate with families and others to work toward a system of integrated services for families with infants, children, and teens, and especially those with special health care needs.

Performance Measure:
None at this time.

Infrastructure Building Services:

- There is interagency collaboration in the Alaska Early Comprehensive Childhood Systems (ECCS) Plan developed by the Office of Children's Services.
- The Section Chief of WCFH (Title V/CYSHCN Director) and program staff work closely with primary health care staff responsible for FHQCs and community health centers to ensure needs of children, pregnant teens and CSHCN are considered in their delivery of services.
- The Autism and Parent Services Manager actively works with parent representatives to develop integrated programs. In collaboration with Family Voices and the Family to Family project at the Stone Soup Group, a parent advisory group meet or conference call in to discuss the system of care for CYSHCN.

Population Based Services:

- The Section Chief of WCFH (Title V/CYSHCN Director) will continue to participate with the All Alaska Pediatric Partnership in the identification of pediatric sub specialty needs and recruitment so that specialized care can be offered closer to the child's home community.

Enabling Services:

- Parent navigation services are offered through a grant with the private non-profit group,

Stone Soup Group, and parent navigators have been trained in several communities to assist families. Parents are active on the Autism Alliance Ad Hoc committee and Steering committees, the Epilepsy steering committee (coordinated by the Center for Human Development at the University of Alaska-Anchorage), and all advisory committees sponsored by WCFH.

Direct Services:

- WCFH continues to sponsor genetics, metabolic, cleft lip/palate, autism screening, and neurodevelopmental disorder clinics in communities throughout the state, based on need.

Priority # 4. Reduce the risks associated with unplanned pregnancy and teen pregnancy.

Performance Measure:

- % of women who recently delivered a live birth and are not doing anything now to keep from getting pregnant. (state)
- Rates of teen pregnancy, 15-17 years of age, is a national performance measure.

Population Based Services:

- WCFH staff provides information and training for health care providers and public health professionals on contraception counseling pregnancy prevention and intimate partner violence prevention. Training is offered at professional association meetings, providers offices and at tribal community health aide training.

Enabling Services:

- WCFH collaborates with the Division of Public Assistance on their teen and out-of-wedlock pregnancy prevention program by sponsoring provider training for IUD and Implanon insertion techniques, contraceptive supplies and educational materials especially where rates of teen and out-of-wedlock pregnancy are highest.
- Title V monies fund three nurse practitioner contracts for family planning services in areas of the state where access is minimal.

Priority # 5. Reduce dental caries in children 0 - 21 years of age.

Performance measure:

- Percent of mothers who report tooth decay in their 3-year old child.

Infrastructure Building Services:

- The state's Dental Officer works with the Alaska Dental Society on workforce development issues to expand access to dental services in rural Alaska, administering contracts with pediatric dental providers to increase access to services for children enrolled in Medicaid/SCHIP, participating in the development of the tribal Dental Health Aide Program, and developing pediatric resident itinerant rotations in Alaska.
- The State's Dental Officer participated in the development of the tribal Dental Health Aide Program and in the development of pediatric resident itinerant rotations in Alaska.
- An Oral Health Survey of kindergartners and third graders is conducted every two years but is dependent upon grant funding.
- The State's Dental Officer oversees the enrollment of pediatric dental providers in support of increasing access to services for children enrolled in Medicaid/SCHIP.

Priority #6. Reduce intimate partner violence (IPV) including teen dating violence.

Performance measure:

- Percent of high school students (grades 9-12) who were hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the 12 months before the survey.
- Percent of women who recently had a live-born infant and reported experiencing intimate partner violence before, during or after pregnancy.

Infrastructure Building Services:

- PRAMS, CUBS, BRFS and YRBS provide some data on different aspects of IPV but there is no comprehensive surveillance system to measure the burden of IPV on MCH populations.
- The Adolescent Health Manager is an active participate in the CDC's Domestic Violence Prevention Enhancements and Leadership Through Enhancements (DELTA) program which addresses intimate partner violence.

Population Based Services:

- This issue is addressed primarily through the Family Violence Prevention Project. The MCH Title V block grant funds staff who oversee the resource center that contains materials on education and prevention of domestic violence.
- The Adolescent Health Manager is actively involved in promoting education around teen dating violence. A teen advisory committee will collaborate with the Domestic Violence Network in rural and bush locations to decrease teen dating and intimate partner violence.
- In FY2010 the Governor declared domestic violence to be a priority and new legislation strengthened laws concerning domestic violence and sexual assault.

Priority # 7. Reduce risk factors associated with preventable post-neonatal mortality due to SIDS/asphyxia.

Performance measure:

- Percent of mothers who recently delivered a live birth and who reported having one or more environmental factors in the home that are associated with SIDS/unexplained asphixia. (Environmental factors include laying baby down to sleep on side or stomach; baby sleeps with pillows, plush toys, etc; smoking allowed in home) (state)
- A related indicator is the National outcome measure #4, postneonatal mortality rate per 1,000 live births.

Infrastructure Building Services:

- Data from the Maternal Infant Mortality Review (MIMR) is provided to programs, health care providers and communities for program planning and education that focus on prevention related activities such as the Back to Sleep and Never Shake a Baby campaigns.
- A Safe Sleep coalition was formed in 2009 to work on the issues of safe sleep of all Alaska infants. Cultural sensitivity will be applied to social messaging.

Population Based Services:

- The state has actively engaged all birthing facilities to participate in educational campaigns.

Priority # 8. Support communities to increase family and youth resiliency.

Performance measure:

- Percent of youths who reported a parent talks to them about school once or twice a month or more.

Infrastructure Building Services:

- The Adolescent Health program manager actively collaborates with many state and private organizations to develop programs for building youth assets. Stand Up Speak Up will be evaluated this year.

Enabling Services:

- The Stand Up Speak Up campaign to encourage teens to speak out against violence is a collaboration with DELTA, the Alaska Council on Domestic Violence and Sexual Assault, and CDC.

- A teen advisory group, the Youth Alliance for Healthy Alaskans (YAHA), was formed by the WCFH Adolescent Health program manager to advise on teen programs. A YAHA-led mini-summit on prevention of teen pregnancy was held as part of the 2010 Title V Needs Assessment process.
- The Adolescent Health program manager co-sponsors Lead On! with the Alaska Network on Domestic Violence & Sexual Assault. This is a state-wide group of youth and adults who are interested in promoting non-violence and equality in their communities (website: http://www.andvsa.org/?page_id=530) . The Lead On! mini-summit scheduled for October 2010 will include many activities to teach teens leadership skills.
- A grant has enabled a Peer Helper program in Mat-Su schools so teens can teach a curriculum on pregnancy prevention.
- The Section of Chronic Disease Prevention and Health Promotion manages grant programs focused on youth asset building and suicide prevention. For example, the Anchorage Youth Development Academy trains adults who want to learn youth development strategies.

Priority # 9. Reduce the prevalence of obesity and overweight throughout the lifespan.

Performance measure:
- Percent of mothers who report their 3-year-old child had a BMI greater than the 85th percentile (overweight and obese). (state)

Infrastructure Building Services:
- The Section of Chronic Disease and Prevention collaborates with Anchorage School District to analyze the prevalence of overweight and obesity among school age children. WCFH is investigating ways to incorporate weight surveillance statewide through other programs.
- Obesity is a priority for the interdivisional preconception and interconception planning teams
- WCFH participates in the Mayor's Task Force on Obesity in Anchorage.
- Nutrition education is disseminated through the WIC program.

Priority # 10. Increase universal screening for post partum depression in women.

Performance measure: Percent of women who delivered a live birth and had a provider talk to them about post partum depression since their new baby was born. (state)

Infrastructure Building Services:
- PRAMS and CUBS surveillance programs continue to be a source of data on mental issues for women surrounding the pregnancy period and for women with toddler-aged children. A significant increase in capacity to address this issue is needed.
- The MCH Title V Director participates on the DHSS Commissioner's Child Policy Team which is focused on improving instate access and infrastructure of behavioral health services. In addition, the MCH Title V Director is actively involved on the steering committee and subcommittees for the ECCS grant focused on behavior health training, access and financing strategies.

Priority # 11. Strengthen quality school-based health care and health promotion.

Performance Measure:
None at this time.

Infrastructure Building Services:
- An advisory committee of school nurses has been established. A needs assessment will be conducted in Fall 2010. These efforts will dictate future activites and performance measures.

Priority # 12. Implement standardized screening for developmental delay and behavioral health in children 0 - 21 years.

Performance measure:
- Percent of children enrolled in Medicaid receiving EPSDT screening. (state)
- HSCI #2 (% of Medicaid enrollees whose age is less than one year who received at least one initial or periodic screen)
- HSCI #7b (% of EPSDT eligible children aged 6 through 9 receiving any dental health service during the year).

Infrastructure Building Services:
- WCFH participated in the ABCD national initiative. An interdepartmental committee led jointly by the Title V Director and the manager of the ECCS program is developing a proposal to require the use of either Ages and Stages or the PEDDs in an EPSDT well child exam as a requirement for Medicaid payment.

Population Based Services:
- The same interdepartmental committee is recommending the use of MCHAT or CHAT for toddler autism screening. Education regarding developmental screening is offered to tribal community health aides and practitioners. Additional training modules for early interventionists, nurses, and other direct health care providers is offered or in development.

Enabling Services:
- Federal grant funds from the Combating Autism Grant and some Title V MCH monies are used to purchase resource materials, screening tools and sponsoring professional education. Outreach education to parents emphasizes well child screens with developmental components.

Priority # 13. Develop capacity to help families navigate the health care system.

Performance Measure:
None at this time.

Enabling Services:
- Parent navigation services are offered through a grant with a private non-profit group. The Stone Soup Group, and parent navigators have been trained in several communities to assist families.
- Parents are active on the Autism Alliance Ad Hoc committee, the Epilepsy steering committee (coordinated by the Center for Human Development at the University of Alaska-Anchorage), and the neurodevelopmental planning committee, all coordinated within WCFH.

Priority # 14. Acknowledge the importance of men in MCH programs.

Performance Measure:
None at this time. This new priority. It reaffirms the continued emphasis on centering health around the family. We will develop ideas over the upcoming five year planning period on how to incorporate this priority, and develop capacity, in MCH programs.

Priority # 15. Reduce late preterm cesarean sections

Performance measure:
- Number of cesarean births delivered at 34 - 36 completed weeks of gestation per 100 total births. (state)

Infrastructure Building Services:
- Infrastructure activities include monitoring trends using PRAMS and Vital Statistics data, and research regarding health outcomes of the infants.

/2013// See comment on revising this goal in the Section IV A.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	44	195	115	103	157
Denominator	44	195	115	103	157
Data Source		Alaska Newborn Metabolic Screening Program	Alaska Newborn Metabolic Screening Program	Alaska Newborn Metabolic Screening Program	Alaska Newborn Metabolic Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
Data source: Alaska Newborn Metabolic Screening

a. Last Year's Accomplishments
The percent of infants screened in the State in CY2011 was 100%. The program manager continued with educational efforts addressing collection techniques, confirmatory testing requirements, and specimen transport time. These educational presentations often included continuing education credits. All infants identified with MCAD, VLCAD, amino acid disorders, and CAH in CY 2011 were referred to the Genetics and/or Metabolic Clinics conducted by the State of Alaska. Parents of children with these disorders needed genetic counseling and advice on their child's disorder. Children diagnosed with endocrine disorders and cystic fibrosis were referred on to the appropriate specialists. All of the conditions diagnosed through the newborn metabolic screening program are reportable to the Alaska Birth Defects Registry, and the program manager provided the registry with this information on a quarterly basis. The number of confirmed cases of

CPT-1 continued to increase. The educational DVD was widely distributed to families with infants identified with CPT-1 through screening and to health providers in the villages providing care for these infants. More than 148 confirmed cases of a carnitine disorder called CPT-1 were found in the Alaska Native population again this calendar year. Biochemical geneticists from Oregon are working with Alaska physicians to try to determine the significance of this new finding. Collaboration with Alaska Native Tribal Health Consortium has been implemented. All infants to date have been from either western or northern Alaska. The NBMS Advisory Committee held its regular 3x/year meetings with discussions on CPT-1, oral health for CYSHCN, and a demonstration of the combined newborn hearing screening/newborn metabolic screening database.

Activities for work with the Western States & Territories Genetics Collaborative (WSTGC) included attending an annual meeting and working with subgroups identifying needs in the area of genetics.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue with education and communication for providers on tandem mass spectrometry, endocrine, and hemoglobin disorders		X		X
2. Continue education and monitoring of specimen quality to assure a high level of screening is conducted				X
3. Provide community education through presentations at hospitals, birthing centers, professional organization meetings, and health fairs				X
4. Refer infants identified with disorders detected through the screening program to State-sponsored Genetics and/or Metabolic clinics	X			
5. Provide information on reportable conditions to the Alaska Birth Defects Registry on a quarterly basis			X	X
6. Convene the Newborn Metabolic Screening Advisory committee on a three times per year basis to develop policies and review the program activities				X
7. Continue to work with the EHDI web-based database vendor to enhance the reporting and searching function of the metabolic integration				X
8. Look ahead to implementation of SCID screening and plan educational activities around this addition			X	
9. Continue with active participation on the Western States & Territories Genetic Collaborative grant to improve access and education about genetics services in Alaska			X	X
10. Continue collaboration with Alaska Native Tribal Health and Oregon Health & Science University to educate families and medical staff regarding CPT-1 and by distribution of the DVD and information card developed for this process		X		

b. Current Activities

Infants diagnosed with fatty acid oxidation disorders and organic acidemia disorders are referred to the Metabolic Clinic conducted by the State of Alaska. Infants identified with hypothyroidism and CAH are referred to the Alaska based pediatric endocrinology clinic and started on treatment. Infants identified with cystic fibrosis are referred to the local pediatric pulmonologist. Infants with hematologic disorders are referred to local hematologists.

To date for CY12, there are infants diagnosed with cystic fibrosis, Hyperphe, and CPT-1. Referrals are made to specialists and the DVD along with a newly designed rack card is sent to all CPT-1 families.

The NBMS Advisory Committee holds its regular meetings three times per year with a report update on CPT-1 activities and an educational presentation on CAH presented to date. Committee members include local pediatricians and sub specialists, hospital laboratory staff, clinic and hospital nursing staff and state program staff. Ongoing educational efforts in community hospitals include presentations to physicians, nurses, and laboratorians at hospitals and professional organizations regarding the screening program, proper collections techniques, and proper follow-up testing of presumptive positive screens. The revised newborn screening regulations are in place with requirements for two screening samples to be collected.

c. Plan for the Coming Year

WCFH anticipates the need for continuing education efforts regarding the lesser-known conditions identified through expanded testing with tandem mass spectrometry as well as new conditions being recommended by the Secretary of Health and Human Services Advisory Committee on Heritable Disorders in Newborns and Children which currently includes SCID. Most important will be education on the confirmatory testing process including proper specimen collection and shipment to the appropriate testing facility.

The current NBMS Program Manager will be retiring after the first quarter of FY13 and turning over the program responsibilities to existing WCFH staff. A Nurse consultant staff member will follow-up on abnormal screens, attend the WSTGC meetings, conduct educational interventions, and organize the advisory committee meetings while the other person will follow-up on improperly collected specimens and send out the quarterly Practice Profile reports.

The Newborn Metabolic Screening Advisory Committee will continue to meet quarterly to discuss concerns and issues surrounding newborn screening and future trends.

Ongoing work with the Western States & Territories Genetics Collaborative and other children's health programs including the Early Hearing Detection and Intervention (EHDI) Program, Specialty Clinics and Genetics and Birth Defects Clinics will continue during this next year. The WSTGC will continue a focus on telemedicine, supporting existing outreach clinic efforts, working on increasing coverage of medical foods and better reimbursement rates for genetic testing.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**11251**			
Reporting Year:	**2011**			
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**	**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received**

					Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	11251	100.0	0	0	0	
Congenital Hypothyroidism (Classical)	11251	100.0	80	4	4	100.0
Galactosemia (Classical)	11251	100.0	1	0	0	
Sickle Cell Disease	11251	100.0	1	1	1	100.0
Biotinidase Deficiency	11251	100.0	2	1	1	100.0
Amino Acids	11251	100.0	10	1	1	100.0
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	11251	100.0	3	1	1	100.0
CPT-1 Deficiency	11251	100.0	148	148	148	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	11251	100.0	3	1	1	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	11251	100.0	2	1	1	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	61	61	61	61	54
Annual Indicator	51.8	51.8	51.8	51.8	66.8
Numerator					
Denominator					
Data Source		Child and Adolescent Health Measurement Initiative	Child and Adolescent Health Measurement Initiative	Child and Adolescent Health Measurement Initiative	Child and Adolescent Health Measurement Initiative
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	54	55	55	56	70

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
/2011 Although this indicator covers age range 0 - 18, the data is defined for children ages 0-17. This is the latest data available.

a. Last Year's Accomplishments
The Section of Women's Children and Family Health (WCFH) supports families of CYSHCN in decision-making and ensures satisfaction with the services they receive by aligning with the MCH pyramid goals of building infrastructure, population-based services, enabling services, and direct services. Key to the support to families is the use of and collaboration with community partners. The CYSHCN framework revolves around system building throughout the life span and families are key players in the assuring this framework is applied. Last year, special key partners included Stone Soup Group (SSG), infant learning program (ILP), and Public Health Nursing (PHN). SSG continued to serve in a primary role as a liaison with the parents of Alaska's CYSHCN; the ILP partnered with us on several key educational outreach campaigns; and PHN supported efforts statewide as a safety net for early identification and secondary care coordination. Other community collaborators include Alaska Native Tribal Health Consortium, Anchorage School District, and the Autism Society of Alaska. Within the State of Alaska, the Division of Education and Early Development and the Division of Behavioral Health Services provided supportive essential enabling services and proved to be a pivotal role in providing support to families as they

started the journey as families of children newly diagnosed with hearing loss, genetic disorders, Cleft Lip/Palate (CL/P), or autism. Like all families, Alaska families had to learn new terminology, develop long-term relationships with new providers and acquire the needed information to make informed decisions.

Specialty clinics were held for CL/P, genetics, metabolic genetics, and neurodevelopment. Clinics continued that were expanded in 2010 to 11 regional hub communities for autism. With rapidly rising autism numbers, work continued to focus on early identification, standardized tools for screening, and workforce development. The ability to provide adequate treatment and services continued to be a high priority. Though much less community outreach was done in FY 12, the neurodevelopmental clinic used the contacts in their distribution and marketing of coming clinics. During FY11, a total of 77 patients were seen in the metabolic clinic; 216 patients were seen in genetics clinics; 112 in the CL/P clinic; and 81 at the pediatric neurodevelopmental outreach and autism screening clinic. One hundred percent of newborns were screened for metabolic disorders and over 95% were screened for hearing loss. Title V funded parent navigators' travel to outreach clinics. They assisted families who needed financial resources, shared options, and helped guide parents after a treatment plan was made in the CL/P and neurodevelopmental clinics.

Post-clinic evaluations were conducted on CL/P, genetic/metabolic, and neurodevelopmental clinics. Valuing family input, the surveys determined high satisfaction with access to the specialty clinic and parent navigation services provided by the SSG. CL/P reported 93% post-clinic satisfied to highly satisfied scores; genetic clinics reported 95% satisfied to highly satisfied post-clinic scores; and the neurodevelopmental clinics reported 94% of families completing the post-clinic evaluation were satisfied to highly satisfied and would likely or definitely recommend the clinic to family and friends. WCFH continued to hold quarterly meetings with the SSG parent navigators to continue to refine and improve service delivery and access to services. The goal of the post-clinic satisfaction surveys were to determine how families felt about both the services offered and the sense of being family-centered.

The APSM initiated a new Statewide Family Advisory Committee to be held as trimester meetings in collaboration with the state's Family Voices representative and the Children's Hospital at Providence Family Support Services Manager. Efficiently using the family time, the advisory group held 2 meetings to date with a strong return rate of parent participants. Significant issues associated with family needs and coordination of services was the highest priority for all three agencies.

The metabolic nutritionist who travels to clinics from Oregon helped arrange a family event for families with a child who has phenylketonuria. Families learned how to cook low-phe foods for their children and were delighted to connect with other families who are dealing with the same issues. This will become an annual event.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maximize and increase utilization by 10% of the number of available appointments for outreach clinics in public health centers, Providence Hospital, and clinical spaces easily accessible to parents throughout urban and rural Alaska	X			
2. Conduct community educational trainings on family behavioral intervention tools at pediatric neurodevelopmental outreach clinics in rural hub communities	X			
3. Continue support of parent navigation services with MCH Block Grant funds for CL/P, hearing loss, and for children		X		

diagnosed with autism and other neurodevelopmental conditions				
4. Update and regularly administer client/family satisfaction surveys for the genetic, PND and CL/P clinics			X	
5. Increase parent participation in the Statewide Family Advisory Committee from 6 to 10 parents; continue parent involvement on MCH supported Perinatal, EHDI, CYSHCN, Newborn Metabolic Screening, and youth advisory committees		X		
6. Continue the annual PKU family event to provide education and support for families with a child with PKU		X		
7.				
8.				
9.				
10.				

b. Current Activities

An accomplishment is successfully holding clinics in public health centers, building upon the PHN and WCFH collaboration on early identification and supporting the development of systems of care in a child's home community. PHN reported 1395 children had developmental screenings conducted in FY 11, an effort in part to collaborate and conduct awareness efforts to increase the numbers of referrals for early identification. SOA staff from WCFH actively collaborated with EPSDT staff of Division of Health Care Services to improve standards of care across all Alaska. The MCH block grant continued funding of parent navigation services at the outreach clinics is key in keeping families in their home community, giving support and referral at the local level, and efficiently serving families, thus avoiding unnecessary delays to families and their children in need of services. Families are involved in decision making through MCH supported perinatal, EHDI, CYSHCN, NBMS, Statewide Parent Advisory Group, and a Youth Advisory Committee for young Alaskans. A new public health specialist is implementing the MCH-Pediatric emergency preparedness program. She is conducting preparedness assessments of communities for CYSHCN, pregnant and postpartum women, and adults with disabilities.

The PKU families attended another event to learn about food options and received input from a psychologist on how to deal with food and teens.

c. Plan for the Coming Year

In FY 2013, WCFH will continue to host 10 clinics statewide in public health centers and private clinics that provide easier access to families of CYSHCN, especially those with neurodevelopmental concerns. As earlier identification and consistent use of standardized tools become routine, we hope to see improvement in the mean age of children referred and understanding the early intervention and treatment, especially prior to the 8th year, will lead to significantly better outcomes. Efforts to educate community providers and get earlier identification require constant educational efforts and parent awareness. Decreasing the age of referral will increase parent satisfaction as evidence-based intervention highly recommends services prior to age 5. With the success of advisory groups in FY12, we will continue with inclusion of families of CYSHCN to refine service delivery, improve system development, and improve the quality of life for the families served through established advisory groups. Awareness building activities through focus groups and educational outreach leads to improved family input into policy decisions and program development. Parent navigation services for clinics will continue as a much appreciated activity of clinic outreach. Parent satisfaction surveys will continue to be analyzed and evaluated on the content of the questions and ways to improve the return rate will be explored. Efforts will be made to conduct more educational outreach to communities during the FY 2013 by promoting opportunities to train as part of the marketing to communities, hoping for a 50% increase in outreach and education opportunities from FY 2012. The goal for EHDI is to increase newborn hearing screening to 100%. Emergency preparedness assessments will begin the next stage of

integrating preparations and planning for those experiencing disabilities. Annual events for families with children who have PKU will continue as the families really enjoy these educational and bonding sessions.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	50	45	45	45	41
Annual Indicator	39.3	39.3	39.3	39.3	42.8
Numerator					
Denominator					
Data Source		Child and Adolescent Health Measurement Initiative	Child and Adolescent Health Measurement Initiative	Child and Adolescent Health Measurement Initiative	Child and Adolescent Health Measurement Initiative
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	41	43	43	44	44

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2009
/2010/ 2011/ Although this indicator covers age range 0 - 18, the data is defined for children ages 0-17. This is the latest data available.

a. Last Year's Accomplishments
Parents of CYSHCN are overwhelmed in their attempt to coordinate their children's health care, to navigate systems and payment models, and to advocate for support in the education and social services systems. During last fiscal year, the section of WCFH identified through a literature review and family input that the need for a targeted effort focused on a pediatric medical home project is desperately needed. During the spring of 2011, a comprehensive needs assessment and search for funding was conducted to identify, plan, and model for population-based enabling services delivery to establish a systematic response to address issues families face with CYSHCN ages newborn through 21. Using the medical home model as foundation, a pilot project was written and submitted to use health care professionals as care coordinators in two trial sites. The proposed state plan continued to use the Bright Futures guidelines and standardized developmental screening tools that institutionalized the medical home model across the State for a systematic integration of CYSHCN into care coordination through a medical home.

A targeted example of other coordinated care delivery was the Cleft Lip and Palate (CL/P) clinic which continued both in Anchorage and Fairbanks. This clinic utilized the on-going care of highly skilled providers in the dental, surgical, and nutrition fields. Families were able to come to one location and see all the necessary specialists. This demonstrated a highly effective system of care coordinated around the needs of the child and the family. The genetic clinics were held in four communities around the state and held twice at Alaska Native Medical Center (ANMC). At ANMC families were offered the opportunity to revisit providers who have seen their child previously or had access to the child's extensive chart. This helped maintain the concept of the medical home, kept a highly specialized care plan up-to-date and in one place. ANMC sometimes serves as the medical home for routine care of many families living in rural Alaska. CL/P staff joined a work group at ANMC to improve case management services for families who live in rural areas of the state. Physicians who referred patients into the genetics clinics received reports which detailed plans and testing needed by these children. Communication between the medical home and the specialists was imperative to provide optimal care for these children. During FY 2011, all 11 clinical sites held PND clinics. Health care providers specializing in this area met with families and screened for neurodevelopmental concerns and offered recommendations through written reports that were sent to both the family and the primary care provider. This assured that there was consistent communication back to the medical home on screening results.

During the last year, the Early Hearing Detection and Intervention (EHDI) program continued to educate primary care providers about hearing screening protocol. The protocol states that when a child or family is identified with a hearing loss, providers are to refer the family to parent navigator services to aid the family in meeting goals regarding early intervention services. The parent navigator works to assure the medical home is aware of the treatment plan and that the family is linked to other services that are needed.

Stone Soup Group (SSG) parent navigators continued to work closely and collaboratively with

State of Alaska clinic coordinators and provided services in both rural and rural Alaska. The SSG, a community-based family support organization, is the state's Family Voices representative agency and serves as the Family-To-Family Health Information Center grantee. Stone Soup Group partnered to develop collaborative systems for families and has devoted significant efforts to serving new populations with grants for services to military families and families in transition. Recognizing the value of parent navigation services, The Children's Hospital at Providence hired permanent parent navigation staff for the Providence Autism Diagnostic Network as part of a seamless goal of providing coordination of services through the pediatric neurodevelopmental outreach and autism screening clinics.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with and educate community providers on new resources available for CYSHCN, specifically those affected on the autism spectrum disorder		X		
2. Annually increase the percent of children with special health care needs age 0-18 who report receiving coordinated, ongoing, and comprehensive care within a medical home		X		
3. Support and maintain 100% access to parent navigation services (PNS) for parents of children with CL/P, infants identified with a hearing loss, and those affected by autism and other pediatric neurodevelopmental disorders		X		
4. Surround and support full-integration of care coordinators on the CYSHCN team for the 2 medical home model clinic pilot sites	X			
5. Evaluate and adjust available appointments for pediatric neurodevelopmental screening clinics at rural sites; monitor and adjust to meet demand to better serve communities with higher needs	X			
6. Educate primary care providers regarding newborn hearing screening regulations and the protocol regarding infants/children identified with hearing loss			X	
7. Ensure 100% of infants identified with a metabolic disorder on newborn screening receive care from the State sponsored metabolic genetics clinics	X			
8. Monitor developing regional trends of the carnitine palmitoyl transferase deficiency disorder and work with public health officials to educate the public of the concern				X
9. Build care coordination capacity in pilot sites and statewide through use of the nationally developed pediatric card coordination curriculum				X
10.				

b. Current Activities

WCFH collaborated and educated community providers during outreach clinics on resources available for CYSHCN, specifically those with autism spectrum disorder. Efforts focused on successful linkages using local partners in regional hubs such as the regionally-based parent navigators, infant learning programs, head-start agencies, and school districts. Utilizing funds from the combating autism initiative, Bright Futures guidelines set the standard for the use of a standardized screening tool. Kits were purchased and distributed throughout Alaska as part of the Learn the Signs/Act Early Campaign project. On-going attendance and participation in meetings maintain constant collaboration and focus on coordinating care across divisions,

sections, and community agencies.

Efforts to collaborate and educate rural community health and medical care providers on new resources, specialists, service providers, and program planning for CYSHCN continue in work with the DPH public information office, creating promotional documents on autism for providers and families.

WCFH created a unique educational resource on disaster preparedness for families with CYSHCN and more than 11,000 copies were disseminated statewide.

Two Pediatric Care Coordinators were recently hired through a HRSA funded state implementation grant to provide family centered services and community outreach in two local medical clinics serving children with special health care needs.

c. Plan for the Coming Year

Through the medical home demonstration (D70) grant effort, the CYSHCN team will utilize the PND outreach clinics, emergency preparedness, and EPSDT tools as educational opportunities to continue to operate collaboratively. Parents of children with chronic conditions such as asthma, epilepsy, heart conditions, and hemophilia who report an inability to access structured support or care coordination will, in two locations, experience care coordination as a pilot project. There currently is no service or agency that supports comprehensive care coordination unless the child meets criteria for Part C (Early Intervention) or Medicaid Waiver Services for developmental disabilities (DD). On-going and targeted collaborative efforts are needed to integrate the use of American Academy of Pediatrics (AAP) Bright Futures guidelines into tribal health and private clinical practice of early and continuous screening of children newborn through 21. Families will benefit from improved coordinated and comprehensive care within the medical home as the SOA continues to collaborate with and educate community providers on new grant opportunities, service options, and program development for CYSHCN.

The highly successful PN in all the outreach clinics will continue to serve the families getting appointments for the outreach clinics and for screening programs. WCFH will sponsor and support conferences, webinars, and workshops on parent needed services. WCFH will continue to monitor and be flexible on the appropriateness of the clinics and honor the traditions, customs, and cultures of the families in ultra-rural Alaska while trying to efficiently deliver the highest quality of care available.

When infants are diagnosed with a hearing loss, it is essential the primary care provider have current referral information so the program manager will ensure they receive timely information. As infants screen positive for metabolic conditions, families will be referred into the state sponsored metabolic clinic where they will be evaluated by a specialist and meet with a metabolic nutritionist. Reports will be shared with the child's medical home as well as with the families. The CL/P workgroup is near completion of a family binder which will be placed in all hospitals and contain information to be given to families when a child is born with cleft lip and/or palate.

The MCH/CYSHCN Emergency Preparedness Manager will implement a newly received CDC grant designed to address health disparities faced by individuals experiencing disability, including CYSHCN. The grant has five health topic areas: oral health, obesity prevention, emergency preparedness, cancer screening, and tobacco cessation. Programming in the former three topic areas will have substantial impact on Alaskan CYSHCN, building on existing partnerships with the Governor's Council on Disabilities and Special Education and the Section of Emergency Programs to reach an estimated 18,000 individuals by the end of FY13.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	60	70	70	70	63
Annual Indicator	62.2	62.2	62.2	62.2	56.7
Numerator					
Denominator					
Data Source		Child and Adolescent Health Measurement Initiative	Child and Adolescent Health Measurement Initiative	Child and Adolescent Health Measurement Initiative	Child and Adolescent Health Measurement Initiative
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	64	66	67	67	67

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
/2010/ Although this indicator covers age range 0 - 18, the data is defined for children ages 0-17. This is the latest data available.

a. Last Year's Accomplishments
Insurance information was collected and tracked for all children accessing state-sponsored services for children and youth with special healthcare needs (CYSHCN). WCFH collaborated and advocated for the needs of CYSHCN with Alaska's Denali KidCare (DKC) and Medicaid programs. A contract with the Alaska Native Tribal Health Consortium (ANTHC) provided Indian Health Services (IHS) funds as payer of last resort for genetics and specialty clinics services. Tricare (Department of Defense) covered the cost of clinic visits for military dependents referred to state-sponsored clinics. WCFH staff documented the number of families who self-pay, do not have insurance, or are unable to pay for services even with a sliding fee scale.

At the cleft lip and palate (CL/P) clinic, 58% received government funded aid in the form of Medicaid/Denali Kid Care (54%), or Tricare (4%); 13% were IHS funds; 26% were privately insured and 3% were self-pay.

At the neurodevelopmental outreach and autism screening clinics, 67% were Medicaid/Denali KidCare, 6% Tricare, 1% Indian Health Service, an 25 % had private insurance pay for the services; there was no family who self-paid for services. The current database combined the metabolic and genetics clinics pay sources. For those clinics last year 49% of children were insured with Medicaid/DKC; 2 % IHS funds; 10% Tricare; 36% were funded with private insurances; and self-pay was 1%. There was an unknown factor of 2% who were being processed, declined, or alternate payment was considered but not yet resolved.

Newly developed procedures provided information on another step for autism screening and diagnosis. The Providence Autism Diagnostic Network provided quarterly reports with documentation on funding sources for medical diagnosis. During the last FY, 37% accessed Medicaid/Denali KidCare funds, 3 % self-paid and 60% had private insurance to pay for the comprehensive multi-disciplinary diagnostic process.

Collaboration continued with strong working relationships with ANTHC, Division of Health Care Services, and the SOA Rural Healthcare Committee to ensure our families' needs were met with adequate funding of services.

The EDHI program has a supply of hearing aids for families lacking another funding source.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collect and track insurance information for all children accessing state-sponsored CYSHCN services				X
2. Continue relationship with parent-centered Stone Soup Group to determine trends associated with families on insurance issues		X		
3. . Contract with ANTHC to provide IHS funds as payer of last resort for specialty clinics services	X			

4. Provide genetics, metabolic, CL/P, and neurodevelopmental clinics services regardless of ability to pay; offer reduced fees for self –pay families based on income	X			
5. Continue to work with Medicaid to cover additional formulas for infants identified with metabolic conditions			X	
6. Continue to provide deaf or hard-of hearing children access to hearing aids if families do not have third-party coverage	X			
7. Work with the Division of Public Assistance to streamline and improve the processing of the applications of newly pregnant women seeking healthcare			X	
8. Through the Governor's Council on Disabilities, support their role on the Autism Task Force for the implementation of SB74 with information on children screened and diagnosed through the specialty clinics or diagnostic center				X
9.				
10.				

b. Current Activities

During the legislative session, SB 74 passed requiring insurance coverage for intensive treatment services for children diagnosed with Autism spectrum disorder. This bill's passage is a bright opportunity for families who have children with autism. An Autism Task Force works on details of implementation with representatives from the Senate, House, Gov's Council, mental health service provider, SOA HSS Commissioner, SOA division of insurance, private insurance provider, and a family member.

A significant issue is tracking and monitoring through a data management system. A request is submitted for a capital project to the State Legislature to create a database that will assist in management and planning, especially as it relates to giving families access to adequate private and public insurance to pay for services.

WCFH maintains a seat on the newly formed Interdepartmental Coordination Council for Early Childhood Systems, a group dedicated to the on-going and coordinated effort of improving young children and families access to quality information and education on early childhood care programs. Newly formed initiatives from PHN is working to evaluate reimbursements for EPSDT, thereby increasing the standardized and evidence-based practice of earlier identification during the crucial early years. Special efforts will be made to work with the Division of Public Assistance to streamline and improve the processing of the applications of newly pregnant women seeking healthcare.

c. Plan for the Coming Year

In the coming year, WCFH staff will participate with the Autism Task Force and their work on implementing SB74 and support the committee's activities by providing current information on screenings, diagnosis, and evidence-based practice intervention recommendations.

Information will continue to be collected and tracked on payer information for all children, especially those CYSHCN. This will be done through a continuing relationship with SSG as parent navigators (PN) for the outreach clinics. Using anecdotal information from PNs, WCFH will monitor the needs of families and have first-hand information on the challenges families face in accessing and paying for services.

Recognizing the drop in adequate insurance coverage for CYSHCN from the national data center, WCFH expects in the coming year to continue collaborative efforts with ANTHC to get needed services covered for CYSCHN. The SOA will continue to provide genetic, metabolic, CL/P and neurodevelopmental services regardless of the ability to pay. The SOA will work to cover additional formulas for infants identified with metabolic conditions, continue to provide hearing

aids to newly diagnosed young children with deafness/ hearing loss who have no other resources, and to assist streamlining the process of newly pregnant women to attain health care.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	75	90	90	90	86
Annual Indicator	85.1	85.1	85.1	85.1	55.2
Numerator					
Denominator					
Data Source		Child and Adolescent Health Measurement Initiative	Child and Adolescent Health Measurement Initiative	Child and Adolescent Health Measurement Initiative	Child and Adolescent Health Measurement Initiative
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	86	87	88	90	60

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the

surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2009
/2010/ Although this indicator covers age range 0 - 18, the data is defined for children ages 0-17. This is the latest data available.

a. Last Year's Accomplishments
Staff of WCFH and several other DHSS programs/divisions worked together with community partners to improve on the systems of care across the lifespan framework and utilized health care/medical homes as the center piece. Last year, the SOA Title V efforts within the Division of Public Health used the MCH Pyramid and focused on infrastructure building by conducting environmental scans, evaluations and assessments, and set standards of care. The Title V Director, Children's Health Unit Manager, Autism and Parent Services Manager, School Health Nurse Manager, EHDI Program Manager, Adolescent Health Manager, and Oral Health Manager actively participated in a wide variety of planning meetings that collaborated with peers across state government and community-based agencies. Though families continue to face challenges as they moved between systems and services, progress was made to make it smoother. Relationship improvements emerged between key stakeholders, including Early Intervention / Infant Learning Program, Public Health Nursing, Stone Soup Group (SSG), Special Education Service Agency, Department of Education and Early Development, the military, ANTHC, ANMC, mental and behavioral Health Systems, Adolescent Health, Medicaid, universities and schools districts. For example, system and relationship building communications occurred during All Alaska Pediatric Partnership meetings, Early Childhood Comprehensive Care and Coordination meetings, and EPSDT planning meetings. Efforts focused on the goals of improved service access, delivery, and payment.

Efforts focused on a seamless service delivery across systems and agencies with a focus on recruitment and retention of medical specialists. Support by the All Alaska Pediatric Partnership brought two new pediatric gastroenterologists, an additional pediatric surgeon with a third to come, two pediatric endocrinologists, one additional pediatric nephrologist, and one additional pediatric hematologist/oncologist In addition the behavioral health community saw their numbers of pediatric psychologists and psychiatrists also increase. Three communities in Alaska successfully recruited and hired newly graduated and experienced pediatricians to their communities as well. All of the generalists and specialists are greatly needed to ensure better systems of care for Alaska families. A specific example of collaborative working relationships included the pediatric dental residents who were included as part of their fellowships to work in the CL/P clinics. The SOA efforts successfully linked other specialty services like speech therapy, perinatology, and genetic counseling. By using a rapid-cycle improvement process, outcomes were continually improved through better organization and process to make for a seamless delivery across systems and agencies.

Parent navigation services continued to be provided as new staff of Stone Soup Group expanded service delivery as well as improved reporting. Likewise, an improved post-clinic survey led to a higher return rate, which led to improved clinic processes. PN services led to creative "out-of-box" thinking to triage the needs of families with available local resources. Similar to case management, this non-profit agency built strong relationships to meet families' needs without the

hindrances of specific protocols so often associated with private offices and publically funded healthcare delivery systems.

The State of Alaska is a place where highly developed cultures, languages, and races, especially from the Pacific Rim, co-exist. The seamless service delivery had to incorporate high sensitivity to cultural diversity. For example, interpreters were provided during outreach clinics and improved provider skill sets to deliver culturally sensitive services. Outreach clinics served as direct service program of the block grant to improve early screening, identification, and intervention services, a high priority last year.

Extensive energy and support went into the grant proposal for the University of Alaska's Center for Human Development's LEND grant. As a community partner, and as a State with no medical school, the Section supported the grant application by reviewing documents, writing sections, and agreed to have students placed in our outreach clinics as part of the student's clinical experience.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Improve parent satisfaction survey return rate for the neurodevelopmental outreach clinic to ascertain parent navigation and coordination of referrals			X	
2. Promote medically-trained interpreters services to translate for non-English speaking families during neurodevelopmental specialty clinic appointments		X		
3. Maintain and update non-English resources for families to understand the medical conditions their child is being seen for as part of specialty post-clinic reports and education		X		
4. Continue service delivery by co-supporting a genetic counselor that is based at the Alaska Native Medical Center and SOA MCH offices	X			
5. By the end of 2012/13 UAA school year, increase from 70% to 90% LEND student placement at rural outreach specialty clinics			X	
6. Maintain SOA trimester parent advisory group that will include all children with SHCN; specifically recruit for family experiencing childhood asthma and diabetes		X		
7. By December of 2013, collaboratively finish and forward to the Commissioner of HSS a DRAFT health plan for Alaskans experiencing disabilities			X	
8. New Pediatric Care Coordinators will determine level of family satisfaction with services for CYSHCN	X			
9. Educational outreach provided to families with CYSHCN on emergency preparedness		X		
10.				

b. Current Activities

WCFH continues to provide specialty clinics statewide for genetics, CL/P and neurodevelopmental and maintains a strong working relationship with SSG. PN with SSG appropriately link families to services and financial resources. WCFH continues to cost-share with ANTHC the salary of a genetics counselor. WCFH successfully placed LEND students in specialty clinics, especially neurodevelopmental outreach clinics. Thirteen students completed their clinical experience, traveling with the PND team throughout Alaska. As part of their training, students are responsible for major projects and collaborating with WCFH staff.

Families have a new opportunity through a collaborative advisory committee between SSG, the Children's Hospital at Providence and the State of Alaska. The group met at SOA offices and used teleconference for those out of Anchorage. This standing parent advisory group with representatives from Family Voices, Family to Family, Family Support Services, and the Parent Services Manager give a broad view and focus on ALL families of CYSCHN, including those with asthma, cancer, CF, diabetes, DD, and genetic or metabolic disorders. Each agency had 20 minutes to discuss questions of interest. Sample questions include: 1) What types of subspecialty services are needed in AK? 2) As a family with a CYSHCN, do you have a plan in event of natural disaster? 3) When thinking about transitions, what is working and what still needs to be done to avoid turmoil for a CYSHCN?

c. Plan for the Coming Year

Challenges in getting access to care when needed for CYSHCN are reported both in-state and on a national level. Though improvements were seen in satisfaction between the family and doctors and the school system, there clearly needs to be efforts in coordination of services which is highly desired by families.

Efforts in the coming year will be focused on collaboration within agencies in the department. Several medical home projects are working simultaneously to create a community or agency based system of care that is organized so families have seamless care coordination across disciplines. WCFH's pilot project will focus on a medical home hybrid model based on work with a federally qualified health center and the subspecialty clinics at Providence Hospital. Pediatric care coordinators will be placed in these two locations. There will be coordination with the CYSHCN parent services manager and the D-70 grant manager in this effort. Work from the statewide parent advisory group directs much of the care emphasis on transitional services.

Within WCFH, collaboration between programs on emergency preparedness for CYSHCN along with MCH populations will be a priority. Statewide efforts will begin in earnest to infuse the special needs of women and children in current plans instead of being a "special population" at the end of State emergency preparedness plans. Staff will work jointly to conduct community assessments and reach out to agencies and providers linked to outreach clinics. Coordination and planning will evolve as communities identify needs, resources, and project potential concerns associated with natural and man-made disasters. A newly awarded federal grant from CDC will help to support systems development in both emergency preparedness and health promotion activities for populations experiencing disabling conditions. Prior work done by an ad hoc committee for the Governor's Council on Disabilities and Special Education, the health planning committee will help to inform a comprehensive health and wellness plan for Alaskans experiencing disabilities. Early work in this fiscal year is serving to identify the need for a more complete assessment, a demonstration of need, and the development of a comprehensive plan for a wide variety of health related activities focusing on obesity reduction and prevention, smoking cessation, environmental accessibility, and community inclusivity.

WCFH will review student evaluations from the UAA LEND project implementation in the outreach clinics as well as the training and educational opportunities provided by SOA staff. Upon evaluation, there will be opportunities to improve the student experience in the coming fiscal year. WCFH will actively work on developing the university and student relationship for effective "student leadership" skill development. It is anticipated as workforce develops, there will be improvement for CYSHCN community-based services and an increase in demand for those services.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	1.5	50	50	50	45
Annual Indicator	42.2	42.2	42.2	42.2	45
Numerator					
Denominator					
Data Source		Child and Adolescent Health Measurement Initiative	Child and Adolescent Health Measurement Initiative	Child and Adolescent Health Measurement Initiative	Child and Adolescent Health Measurement Initiative
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	45	45	50	50	50

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC. /2012/ Although this indicator covers age range 0 - 18, the data is defined for children ages 0-17. 2010 is the latest data available.

Notes - 2009

/2010/ Although this indicator covers age range 0 - 18, the data is defined for children ages 0-17. This is the latest data available.

a. Last Year's Accomplishments

WCFH staff worked collaboratively with peer departments and community agencies to coordinate and support efforts around transitional services for CYSHCN into adult life, including healthcare, work and independence. The Governor's Council on Disabilities and Special Education (GCDSE) continued to lead the coordination of efforts, with the support of WCFH, and is dedicated to finding appropriate educational and training experiences for Alaskan students with disabilities to ensure they not only graduate but are able to transition successfully into work and community life after graduation. SOA departments or community-based agencies work included the Leadership in the Education of Neurodevelopment and Related Disorders (LEND), GCDSE Ad Hoc Committee on Rural Health, Department of Labor (DOL), Department of Education (DEED), Disability Law Center, UAA's Center for Human Development (CHD), Special Education Service Agency (SESA), and Stone Soup Group (SSG). These agencies worked on special projects or goals to make those with disabilities make smooth transitions from high school to adulthood by engaging in meaningful educational or social development in preparation for independent living and reaching individualized goals. This was accomplished by working with families and offering specialized training for both work and social skill development. The current WCFH Autism/Parent Services Manager has served on the Rural Ad Hoc committee as a voting member for the past three years. The mission statement for this group is: Empowering rural communities to create individualized solutions to improve the lives of people with disabilities.

Highlights from these programs and projects last year include the initiation of LEND (professional workforce development); CHD's Partners in Policy Making Youth Committee (self-advocacy skill development); CHD's TAPESTRY project, (Postsecondary Transition Support Program for students age 18 to 21 with intellectual and cognitive disabilities); the GCDSE Rural Ad Hoc Committee; SESA's Educational Transitions Project (designed to improve successful educational transition support project for youth returning from residential treatment back to their home community); and the GCDSE 5-year plan (includes goal setting with DOL, DEED, and DVR on youth in transition, self-advocacy and leadership, employment, and healthy living). The GCDSE supports Project SEARCH/Alaska, a career preparation project for students with disabilities in health care settings. The SSG has Transitional Services and Support and set 3 goals -- to Increase Community Capacity to Support Individuals Who Experience Developmental Disabilities; to Increase Peer-to-Peer Support; and Encouraging Advocacy. CHD has developed a Friendship & Dating curriculum aimed at young people ages 16-21 that the Stone Soup Group itinerant parent navigator piloted. CHD's TAPESTRY project is a postsecondary college experience which helps develop self advocacy skills and engages in career exploration and the development of social skills that lead to employment in a career field or enrollment in a postsecondary educational program, An expansion of training and materials is available to communities to increase beneficiary support services, including training and technical assistance regarding the transition process from pediatric and school based services to the adult services system.

The mission of the Division of Vocational Rehabilitation (DVR) is to assist individuals with disabilities to obtain and maintain employment. The DVR 2011 annual report states a continued focus on improving transient services for youth with disabilities. DVR hired a transition coordinator and holds community forums on transitions. Per their report, 20% of 4239 individuals served are youths under the age of 23. Statistics from the last fiscal year report 52.1 % of Alaskans who submit claims are served as opposed to a national rate of 36.9%. Per the GCDSE, there are approximately 16-17,000 students receiving special education services in Alaska's schools. DVR reports 27 students participated in the Project SEARCH/Alaska program where eligibility criteria determines if the transitioning student must be unable to engage in any substantial gainful work activity because of a medically determinable physical or mental impairment which is expected to last for 12 continuous months.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase the percentage of youth with SHCN who report having services necessary to make transitions to all aspects of adult life including health care and work from 42.2% to 47% by 2015 in the National Data Center survey for CYSHCN		X		
2. Support GCDSE leadership on Project SEARCH/Alaska to increase visibility of youth with disabilities				X
3. Aid the GCDSE by recruiting youth and families for special committees and market specialized trainings for youth, families, and community providers, i.e. Youth with Barriers in Transition and Disability Mentoring Day			X	
4. Actively participate in the GCDSE Rural Ad Hoc Committee				X
5. Support Bring the Kids Home Initiative, ensuring children have the services they need to be served in Alaska through CHD workforce development efforts		X		
6. Assist through referral made to the SSG Transitions support program; local volunteer trainers for dating curriculum, etc.			X	
7. Look at additional activities for youth with PKU to help them transition to adulthood		X		
8.				
9.				
10.				

b. Current Activities

GCDSE has developed Project SEARCH sites in three Alaskan communities--Anchorage, Fairbanks and the Matsu Valley. The Council hopes to expand to other communities and other sites outside of medical facilities in coming years. SSG submitted a grant for funding a transition center and are awaiting word on the grant's approval. SSG worked with a small number, app. 25 transition-age youth, with a variety of transition services needs. Approximately 20% of the youth are outside of the Anchorage area. Focus areas are on guardianship, employment, nutrition, housing, and financial issues.

Disability Law Center is the new home of the Client Assistance Program helping individuals who experience problems when applying for or receiving rehabilitation or independent living services. The GCDSE continues to repeat financial literacy workshops; offers trainings at the Alaska Statewide Special Education Conference with a tract on youth and young adults with disabilities in transition; plans and develops a transition age youth and young adults with behavioral needs subcommittee; and increase community providers to launch the Rural Ad Hoc Committee --a committee devoted to the needs of CYSHCN and access to services.

A PKU cooking class conducted this year was designed to teach youth with Phenylketonuria how to cook so they could eat a more normal diet. This class was for all families with a member with PKU but was especially helpful for the adolescents in attendance.

c. Plan for the Coming Year

The CYSHCN data survey of 2005/2006 reported 42.2 % Alaskans receive the services needed to transition successfully with an increase to 45% in 2011/12. Strategic efforts are needed for youth during transition across the nation and in Alaska.

WCFH will continue to support and compliment the efforts of the GCDSE leadership and SSG on this national performance measure and work with both agencies to increase awareness and

recruitment of additional agencies to work on special projects, new subcommittees, and expand effective programs. WCFH will actively network with agencies and businesses and educate the public on ways to improve the lives of youth with disabilities. As the protected and federally mandated Council, they will serve to represent the needs, create programs, spend resources, seek legislative solutions, and advocate politically for CYSHCN. In the coming year the GCDSE youth liaison will continue to sit on the Alaska Workforce Investment Board's Youth Council and continue the work of being the representative to influence decisions affecting youth in transition. The WCFH Youth Advisory Committee will actively recruit additional youth to represent the special issues and needs of this population.

Regarding workforce development, youth and young adults with disabilities will continue to need meaningful job skill training and work experience through a coordinated effort with the DOL, DEED, and DVR, especially with Project SEARCH/Alaska. The WCFH role will be promotion of Project SEARCH/Alaska in other communities throughout the state.

Web-based technology is especially important in Alaska due to the remoteness and transportation issues for families and youth. The GCDSE Rural Ad Hoc Committee mission, with WCFH representation, will work to empower rural communities to create individualized solutions to improve the lives of people with disabilities. Through a community needs assessment, work will continues towards maximization of technology in rural areas to access key services; support the development of sustainable opportunities for adults to allow them to remain in their community of choice; and to research financial and programmatic resources to meet identified needs. The SOA Vocational Rehabilitation Committee is an active member, recognizing their responsibilities for transitional service needs. Telemedicine will give great freedom of choice to young adults to make decisions about their transitional needs. This committee will continue to travel to rural Alaska to identify transitional needs of CYSHCN.

The Bring the Kids Home project will continue to raise issues and concerns for adults transitioning from residential programs to community placements back in their home in Alaska. Additional opportunities to bring families together that have adolescents with a metabolic disorder will be explored so the young adults can meet and share ideas about transitioning into adulthood.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	86	86.5	87	87	60
Annual Indicator	78.6	76.2	76.2	56.6	74.9
Numerator					
Denominator					
Data Source		CDC National Immunization Program	CDC National Immunization Program	CDC National Immunization Program	CDC National Immunization Program
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	65	65	65	70	80

Notes - 2011
Source: CDC National Immunization Program, personal email from HRSA. * 4 or more doses of DTaP, 3 or more doses of poliovirus vaccine, 1 or more doses of any MMR vaccine, 3 or more doses of Haemophilus influenzae type b (Hib) vaccine, and 3 or more doses of hepatitis B. 5/24/12 ywg

Notes - 2010
Source: AK Dept. of Health & Social Services. Epi Bulletin No. 2. Improving Immunization Coverage Rates in Alaska's Children. Feb. 17, 2011. Hib servies was excluded from 2009 analysis due to a national shortage of this vaccine. This series was not included in the National Immunization Survey as was in prior years. 6/2011

Notes - 2009
Source: CDC National Immunization Program, Immunization Coverage in the US, Immunization Survey, NIS Data: Tables, Articles & Figures. (See the 4:3:1:3:3 series).

This covers CY 2008 which is the latest available data.

a. Last Year's Accomplishments
Early in 2011, Alaska public health nurses (PHNs) worked with the Public Information Office and other partners to distribute the SHOTS Survey, which is an evidence-based tool to identify barriers to immunizations. More than 1,000 surveys were analyzed. The survey identified concerns about the number of shots given at a time and the make up of the shots as Alaska's greatest barrier to immunizations, followed by the importance of shots, and lastly access to shots.

The Alaska Immunization Program (AIP) put on the statewide 2011 Alaska Immunization Conference -- "Science + Safety + Cents, Making It All Add Up". Conference goals included: effectively address vaccine safety concerns, apply strategies to improve vaccine delivery & management in the provider setting, and implement strategies to increase immunization coverage in Alaska. AIP staff and guest educators from CDC National Center for Immunization and Respiratory Disease presented at pediatric grand rounds in Anchorage, Fairbanks, Juneau, and Bethel.

Staff of the AIP presented and/or exhibited at the Anchorage Association for the Education for Young Children statewide conference, Alaska Family Child Care Association conference, Alaska Pharmacists Association, Alaska Physician Assistants Academy, Head Start Health Advisory Committee, and Baby & Toddler Fair.
Alaska-specific childhood & adolescent recommended immunization schedules were updated for 2011 to reflect current ACIP recommendations.

The annual childhood immunization awareness campaign, "I Did It By TWO!", was presented again in collaboration with the Iditarod Trail Committee, taking advantage of the largest event in Alaska every year.
Staff of the AIP presented vaccine & immunization lectures to University of Alaska nursing students.
PHNs provided direct services for immunizations to children in public health centers and via itinerant PHN services across the state. PHNs worked with tribal Community Health Aide/Practitioners (CHA/Ps) and private providers to train and support them in the provision of immunization services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase access to vaccines for underinsured children via limited 3-year state funding		X		X
2. Utilize the media to promote childhood immunizations			X	X
3. Promote group work focusing on increasing immunization rates			X	X
4. Increase enrollment in the VacTrAK registry			X	X
5. Provide perinatal hepatitis B surveillance and case management			X	
6. Provide outreach and direct services for immunizations by PHNs across the state, and train and support tribal CHA/Ps and private providers in the provision of immunization services	X		X	
7. Promote the Bright Futures prenatal visit with a health care provider for the baby			X	
8.				
9.				
10.				

b. Current Activities
Stop-gap legislation was signed into law and offsets decreased federal funding for vaccine procurement. The 3-year state funding increases access to vaccine for underinsured children starting July 1, 2012.
Media campaigns are being utilized, such as Facebook advertising, TV PSAs, an annual Iditarod immunization campaign, and National Infant Immunization Week.

Several groups are focusing on increasing immunization rates, including an Alaska Division of Public Health (DPH) Workgroup, sections within public health, the All Alaska Pediatric Partnership, the Alaska Chapter of AAP, and tribal health.

VacTrAK immunization registry enrollment is increasing. All public health centers are enrolled, and a significant number of provider offices have enrolled.

AIP has implemented a perinatal hepatitis B surveillance and case management program to assure that children born to Hepatitis B positive women receive the birth dose of Hep B vaccination and complete the vaccination series.

PHNs are providing outreach and direct services for immunizations to children in public health centers and via itinerant PHN services across the state. PHNs are working with tribal CHA/Ps and private providers to train and support them in the provision of immunization services.

WCFH is promoting the Bright Futures prenatal visit with a health care provider for the baby as a

way to reduce the problem of immunization late starters. Meetings are planned with perinatal providers and a brochure is under development.

c. Plan for the Coming Year
In 2013 the AIP will work with the Alaska DPH and individual health care providers to increase immunization coverage rates statewide via evidence-based provider intervention strategies identified by the DPH Workgroup to Increase Immunization Coverage in Alaska.

The Alaska DPH Workgroup to Increase Childhood Immunization Rates will continue to coordinate activities in Section of Epidemiology, Public Health Nursing, WCFH, and the AIP to improve childhood coverage rates in Alaska based on the "Community Guide to Evidenced Based Interventions" http://www.thecommunityguide.org/vaccines/universally/index.html In addition the All Alaska Pediatric Partnership, a coalition of private hospitals who care for children in Alaska, the Alaska Chapter of AAP and tribal health, will continue their work to increase immunization rates. The coalition is co-chaired by the Title V/ CYSHCN Director and WCFH staff members are active participant and initiative leaders.

The third biennial statewide Alaska Maternal Child Health and Immunization Conference is scheduled for September 27-28, 2012 in Anchorage. Douglas Diekema, MD will provide a plenary session, "Improving Immunization Coverage: Working with Vaccine-Hesitant Parents" as well as a breakout session, "Strategies for Improving Immunization Coverage."

AIP staff will continue to present the annual childhood immunization awareness campaign "I Did It By TWO!," update VAC-FACTS, present at professional and community meetings, and lecture university nursing students.
WCFH will begin to screen the immunization status of children attending specialty clinics. Processes are under development, such as requesting immunization cards of children scheduled for specialty clinic visits for verification or data entry into the VacTrAK registry.

WCFH will continue to promote the Bright Futures prenatal visit with a health care provider with the baby as a way to reduce the problem of immunization late starters, work with perinatal providers, and develop a brochure. Other possibilities include training obstetrical providers to discuss immunizations not only for pregnant moms, but also promote infant vaccination as part of their OB visits.

Public health nursing will continue to provide outreach and direct services for immunizations to children in public health centers and via itinerant PHN services across the state. They will continue their work with tribal CHA/Ps and private providers to train and support them in the provision of immunization services.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	18	18	18	18	15
Annual Indicator	16.0	18.3	17.8	15.3	
Numerator	271	301	288	251	
Denominator	16888	16439	16186	16354	
Data Source		AK Bureau	AK Bureau	AK Bureau	AK Bureau

		of Vital Statistics	of Vital Statistics	of Vital Statistics	of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	15	15	15	15	13

Notes - 2011
Source: Alaska Bureau of Vital Statistics. 2010 is the latest available data

Notes - 2010
Source: Alaska Bureau of Vital Statistics. 2009 is the latest available data

Notes - 2009
Source: Alaska Bureau of Vital Statistics. 2009 is the latest available data

a. Last Year's Accomplishments
The birth rate for teenagers aged 15-17 years in Alaska in 2010 was 16.3 births per 1,000. The Healthy Alaskans 2010 Objective is 18 per 1,000.

Title V continued to fund nurse practitioners to provide comprehensive reproductive health services, including comprehensive education and counseling, at the Kodiak Public Health Center (PHC) and the Juneau High School Teen Health Centers.

Title V funds also were used for cervical cancer screening services for women of all ages seeking family planning services at all State PHCs. Women with abnormal screening results were referred to the Alaska Breast and Cervical Health Check program for diagnostics and/or treatment as needed.

The WCFH Family Planning Program (FPP) continued to administer the Title X Family Planning Services grant in FY11, offering high quality, low cost family planning and related preventive health services to low income women, men, and teens in communities in the Mat-Su Valley and the lower Kenai Peninsula, in addition to a new site, a federally-qualified community health center (FQHC), in Fairbanks. The FPP Title X services promoted parental involvement in teen decisions to seek family planning services and offered comprehensive sexuality education and counseling, including encouraging abstinence, as a core part of their service delivery.

The Section of WCFH continued work under an interdepartmental agreement with the Division of Public Assistance with the goal of reducing teen and non-marital pregnancy in Alaska. The women's and reproductive health nurse consultant provided skill-building counseling trainings including counseling about unhealthy relationships. The nurse consultant served on the Statewide Sexual Assault Response Team Steering Committee and worked with women's advocates, law enforcement and state prosecutors in an effort to decrease sexual assault in Alaska, particularly in rural and remote communities. The nurse consultant worked with a small subcommittee tasked with revising State protocols for communities needing to establish or maintain sexual assault response teams.

The Adolescent Health Program (AHP) targeted the issues of teen pregnancy and unhealthy relationships by promoting healthy relationships in Alaska's teens. The AHP also provided administrative support for two grants to communities aimed at involving youth in the prevention of teen pregnancy and unhealthy relationships.
The AHP managed two federal teen pregnancy prevention grants, both focusing on teen pregnancy prevention, healthy relationships and STD/HIV prevention. The AHP manager served as an active member of a domestic violence and sexual assault prevention steering committee, linking violence prevention and pregnancy prevention for teens.

The AHP planned and implemented two teen pregnancy mini summits that were attended by high risk Alaska youth and service providers.
The AHP produced a birth spacing/unintended pregnancy prevention brochure aimed at reducing the rate of teen births in Alaska.

The nurse consultant staffed the Reproductive Health Partnership providing reproductive health trainings and patient education materials for health care providers in census areas of the state where rates of births to teens and single women have been higher than the state average for over a decade. A limited supply of long-acting reversible contraceptives was provided at no cost to teens and women of all ages in over 46 rural and remote Alaskan communities. Skills-based trainings, including hands-on, audio conference, self-study and web-based, were offered throughout the year. Informal surveys of rural health workers were conducted in order to learn perceptions about teens' needs for reproductive health care services. Limited access to comprehensive reproductive health services and high cost of effective contraceptives remain the leading concerns.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide funding for nurse practitioners to offer comprehensive reproductive health services at the Kodiak PHC and Juneau High School Teen Health Center	X			X
2. Maintain cervical cytology laboratory contract for all State of Alaska PHCs	X			X
3. Form and administer youth advisory committee focused on pregnancy prevention and violence prevention		X		X
4. Provide fiscal, administrative and clinical oversight to two Title X Family Planning clinics				X
5. Offer professional educational opportunities on topics relevant to teen reproductive health for health care workers from areas with the highest rates of births to teens				X
6. Provide administrative and technical support to for four community grantees and multiple schools for two federal teen pregnancy prevention grants				X
7. Create birth spacing and unintended pregnancy prevention brochure- social marketing campaign			X	X
8. Provide administrative and technical support to two community partners for Youth Development as a Teen Pregnancy Prevention Strategy grants				X
9.				
10.				

b. Current Activities

Most FY11 projects are continuing during FY12.

The WCFH FPP continues to administer the Title X Family Planning Services grant in the Mat-Su Valley, the lower Kenai Peninsula, and Fairbanks. All three sites continue to promote parental involvement in teen decisions to seek family planning services and offered comprehensive sexuality education and counseling, including encouraging abstinence, as a core part of their service delivery.

The AHP continues to manage grants to communities on youth development and teen pregnancy prevention. The AHP continues its social marketing campaign on birth spacing. The AHP is continuing work with the Youth Alliance for a Healthier Alaska, an advisory committee comprised of all youth that advise the State on important matters relevant to teens, including teen pregnancy and violence prevention.

The AHP is working with foster youth and foster parents to promote parent child education about sexuality and healthy relationships.

c. Plan for the Coming Year

In FY13, Title V will continue to fund nurse practitioners to provide comprehensive reproductive health services at the Kodiak PHC and the Juneau High School Teen Health Centers.

Cervical cancer screening services will continue and remain available to women age 21 and older and seeking family planning and related reproductive health services at State PHCs; however, the State PHCs will be enrolled directly in the Alaska Breast and Cervical Health Check program as screening providers, and low income women with abnormal screening results will continue to be referred to the for diagnostics and/or treatment as needed. These services will no longer be funded by the MCH Block Grant to avoid duplicative systems.

FPP staff will continue to administer the Title X Family Planning Services grant serving communities in the Mat-Su Valley and the lower Kenai Peninsula; unfortunately, the site in Fairbanks has decided to cease participation in the Title X Program at the close of SFY12, due to staffing shortages and administrative burden of the program, although this site will continue to provide family planning services, counseling and education to their adolescents clients. As required by this federal program, FPP Title X services at the remaining 2 sites will continue to promote parental involvement in teen decisions to seek family planning services and to offer comprehensive sexuality education and counseling, including encouraging abstinence, as a core part of their service delivery.

Furthermore, FPP staff will continue to forge new partnerships with community health centers around the state in an effort to establish new Title X sites in the future.

All Adolescent Health FY 12 projects will continue in FY 13.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	26	55	55	55	60

Annual Indicator	52.4	55.4	55.4	55.4	55.4
Numerator	1260	457	457	457	457
Denominator	2405	825	825	825	825
Data Source		AK Oral Health Program, 2007 Oral Health Survey.	AK Oral Health Program, 2007 Oral Health Survey.	AK Oral Health Program, 2007 Oral Health Survey.	AK Oral Health Program, 2007 Oral Health Survey.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	60	60	60	60	60

Notes - 2011
Data source: AK Oral Health Program, 2007 Oral Health Survey. Available at http://www.hss.state.ak.us/dph/wcfh/Oralhealth/docs/2007_OralHealth_Children.pdf. The next survey is awaiting funding.

Notes - 2010
Data source: AK Oral Health Program, 2007 Oral Health Survey. Available at http://www.hss.state.ak.us/dph/wcfh/Oralhealth/docs/2007_OralHealth_Children.pdf. The next survey is awaiting funding.

Notes - 2009
Data source: AK Oral Health Program, 2007 Oral Health Survey. Available at http://www.hss.state.ak.us/dph/wcfh/Oralhealth/docs/2007_OralHealth_Children.pdf. The next survey is awaiting funding.

a. Last Year's Accomplishments
In SFY 2011, the Oral Health Program (OHP) completed the third statewide dental assessment of third grade children using the "Basic Screening Survey (BSS)" method. The dental assessment process included state baselines on dental sealants on at least one permanent first molar. The state baseline (2010/2011 school year) for sealant utilization in third-grade children was 46.8% (down from 55.3% in the 2007 BSS and the 2004 BSS at 52.4%). The confidence interval for the 2010/2011 BSS for sealant utilization ranged from 42.9% - 50.8%. Sealant utilization was down for all racial/ethnic groupings and for 3rd graders whose parents reported Medicaid eligibility in the 2010/2011 BSS.

The decrease in dental sealant utilization from 2007 was statistically significant, however the sample method utilized also likely influenced the lower rates. The 2010/2011 sample utilized a sample of schools proportional to size to reduce costs associated with travel to small rural

schools to conduct the dental assessments -- previous BSS projects have found higher sealant utilization in Alaska Native students in these schools. Additionally, several of the urban schools in the 2010/2011 sample had very low student participation in the BSS due to lack of returned parental consent forms.

Data has not been collected on the number of unduplicated Alaska children aged 8-9 with at least one dental sealant applied to a permanent molar paid for by Medicaid. Sealants not billed to Medicaid are not available; therefore the reported sealant utilization from Medicaid claims with past reports would underestimate the sealant utilization in this population.

The OHP and Coalition continue to provide training on child abuse and neglect awareness and reporting requirements (PANDA Project) at least once per year at the University of Alaska Anchorage. The OHP continues to support Medicaid with implementation of dental preventive and enhanced restorative services for adults enrolled in Medicaid (includes coverage for pregnant women); and work with the Head Start Collaboration Office and Head Start grantees on the "Cavity Free Kids" oral health curriculum and other oral health initiatives. The OHP collaborated with the Anchorage Community Health Center on the 2nd year of a dental sealant pilot program at an elementary school with more than 50% of children eligible for the free and reduced school lunch program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support and promote community water fluoridation in all communities of Alaska				X
2. Identify funding to support a statewide dental sealant coordinator			X	
3. Collaborate with 330 funded Community Health Centers to establish dental sealant programs			X	
4. Support coalition activities and the implementation of the comprehensive state oral health plan				X
5. Collaborate with Tribal programs including Head Start and Environmental Health to support dental access, education, sealant application and water fluoridation			X	X
6. Maintain program web site for dental access, oral health information and coalition activity				X
7. Continue technical assistance on information to parents/providers on reducing risks of enamel fluorosis (while still supporting water fluoridation to reduce dental decay)			X	
8. Maintain oral disease burden document describing oral diseases in Alaska and the impact of those diseases on the state				X
9. Work with Commissioner's Office and Alaska Dental Action Committee for continued implementation of adult dental Medicaid services and report findings to the legislature				X
10. Work with Medicaid/CHIPRA program on increasing access to dental sealants for 6-9 year olds and increase access to preventive dental visits for all enrolled children			X	X

b. Current Activities

The Oral Health Program (OHP) conducted year 3 of a school-based (SB) dental sealant pilot with the Anchorage Neighborhood Health Center in March 2012 and applied for a HRSA grant to

expand the sealant program to at least 2 other elementary schools in SFY13--award notice is in August 2012. Funding would also be for additional workshops/training on integration of medical/dental in addressing early childhood caries (ECC) (e.g., oral evaluation and fluoride varnish application by trained medical providers as part of well child exams).

The OHP in collaboration with the oral health coalition is revising the state oral health plan. Priority recommendations include: reducing child consumption of soda/sugar-sweetened beverages; increasing dental access for CSHCN including dentist training; supporting expansion of SB dental sealant programs; and collaborating with medical providers to reduce prevalence/severity of ECC.

The Dental Officer (DO) works with Medicaid staff to develop a dental periodicity schedule for EPSDT and plans to work with Medicaid on the dental initiative from Center for Medicare and Medicaid Services to increase preventive dental visits (all children) and increase dental sealant utilization on permanent molars (6-9 year olds).

The DO and sealant coordinator continue to meet pediatric and Tribal dentists to encourage increased dental visits for children in Medicaid prior to 2 years of age to address high levels of ECC and related hospital-based dental care in Alaska.

c. Plan for the Coming Year

The Oral Health Program (OHP) will continue working with Medicaid to address private dental issues with the program to encourage broader dental participation. The OHP anticipates activities related to dental quality measures for Medicaid/CHIP. The OHP will be highlighting the reduced 3rd grade sealant utilization with Tribal dental programs and other dental providers.

Other planned activities for FY2012 include: work with the oral health coalition and stakeholders to implement recommendations in the new state oral health plan; follow-up to the pilot school-based dental sealant program to explore funding to make these programs sustainable (including with the new HRSA grant if approved); provide resources for implementation of oral evaluation and fluoride application by non-dental health professionals as part of EPSDT well child exams; continue to educate dental providers on the need for early dental visits for children at-risk for caries (age one dental exams); and continued work with the Head Start Collaboration Office and Head Start grantees to establish dental homes and provide education through the "Cavity Free Kids" curriculum training and ongoing technical assistance/training within the Head Start Program.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	5.6	4.5	4.5	4.5	3.5
Annual Indicator	4.1	3.9	3.9	4.6	
Numerator	20	19	19	21	
Denominator	482503	486703	492069	461044	
Data Source		AK Bureau of Vital Statistics	AK Bureau of Vital Statistics	AK Bureau of Vital Statistics	AK Bureau of Vital Statistics

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	3.5	3.5	3.5	3.5	3.5

Notes - 2011
Source: Alaska Bureau of Vital Statistics. 2010 is the latest available data

Notes - 2010
Source: Alaska Bureau of Vital Statistics. The most recent data available is 2007 - 2009. This indicator is reported by 3-year moving averages.

Notes - 2009
Source: Alaska Bureau of Vital Statistics. The most recent data available is 2007 - 2009. This indicator is reported by 3-year moving averages.

a. Last Year's Accomplishments
Alaska's motor vehicle fatality rates for children aged 14 years and younger have been steadily declining since 1993-1995, when the rate was 9.3 motor vehicle related deaths per 100,000 children. That statistic dipped as low as 4.2 motor vehicle related deaths per 100,000 children in 2006-2008 and 2007-2009, with a slight increase to 4.6 motor vehicle related deaths per 100,000 children in the 2008-2010 timeframe. Decreases in these types of children's deaths are related, in part, to the significant efforts of partners dedicated to increasing policy efforts such as the establishment of strong child passenger safety and booster seat laws, as well as ensuring effective practices related to the proper use of child restraints.

The Alaska Child Passenger Safety Program (CPS), located in the Section of Chronic Disease Prevention and Health Promotion (CDPHP), facilitated, coordinated, and supported motor vehicle, bicycle, and pedestrian safety activities and health initiatives offered through the following partner agencies: Alaska Child Passenger Safety Coalition (CPSC), the Health Window Initiative of the Mexico Consulate in Alaska, Office of Children's Services, Alaska Native Health Consortium (ANTHC), and Southeast Alaska Regional Health Consortium (SEARHC).

In SY11, program staff handled logistics for CPSC business meetings and team-building development; presented "Introduction to Child Passenger Safety" three-hour courses in the community; participated in car seat checks held by Coalition partners; disseminated electronic event calendars to Coalition and all Child Passenger Safety Technicians statewide; participated in the development of the Alaska Strategic Highway Safety Plan; and served as a Program liaison with Alaska Tribal Transportation Workgroup (ATTWG) and Alaska Strategic Traffic Enforcement Partnership (ASTEP).

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Support coalition strategic planning and support Coalition Leadership to meet 4 times and Coalition Membership to meet 1 time				X
2. Provide CPS education with recommendations for effective, integrated MV public health policy to policy makers			X	
3. Work with surveillance systems to obtain more detailed data to determine who, what, when				X
4. Provide technical support to communities to gain local NHTSA CPS Fitting Stations classification				X
5. Provide site-appropriate outreach, education & seat safety checks			X	
6. Provide outreach and community and education on provisions and compliance with AS 28.05.095			X	
7. Support local NHTSA CPS Fitting Stations and provide updates on CPRs recalls			X	X
8. Partner with existing partners to augment Safe Routes to School and Bike to Work initiatives.			X	X
9. Encourage integration of suggested CDC MV injury prevention policy: primary violation law; increased enforcement; increased fines			X	X
10. Collaborate with DOT and DPS statistician on compilation of data on enforcement of AS 28.05.095				X

b. Current Activities

Because of reduced federal funding, the CPS program eliminated the designated CPS program coordinator for 2011-2012. Reduced activities have been spread across the three existing injury prevention staff. The three primary focus areas are 1) expanding child passenger safety efforts in rural communities, 2) supporting bike and pedestrian safety efforts, and 3) assisting in the utilization of strong motor vehicle surveillance data to evaluate and drive efforts. CPS is also participating in a statewide coalition to address violence and injury prevention efforts in order to better utilize existing resources. The CPS program researches and disseminates resources on safe use of bicycles, ATVs, snow machines and pedestrian practices for injury prevention, as well as monitoring and disseminating the latest information on child passenger safety equipment.

The CPS program continues to monitor motor vehicle related policy to provide recommendations for Alaska's ability to implement evidence-based injury prevention practices. The program is also collaborating with the Safe Routes to School program through the Department of Transportation to increase communities' ability to support safe biking, walking and running locally. The program is a substantial resource for Alaskans on safety materials.

c. Plan for the Coming Year

In alignment with the Alaska Highway Safety Office's priorities, the CPS will focus on: occupant protection, such as seat belt use and child restraint/booster seat use; pedestrian safety; and bike safety.

The CPS program will continue its leadership role in the Alaska Child Passenger Safety Coalition at the same time that it broadens its Injury Prevention focus by participating in the Alaska's Violence and Injury Prevention program (AKVIP), a statewide collaborative of State, Tribal, health care, education, funding, and planning entities in Alaska. It will continue to outreach and support local, rural efforts to develop and sustain certified child passenger safety technician and designated fitting stations, while monitoring public policy related to occupant safety.

Additionally, CPS will expand its efforts to make Alaska's roadways safe for bicyclists and

pedestrians. Partnering with Safety Routes to School, CPS will link with communities to conduct local planning efforts to increase safety. CPS will also develop and expanding resources for communities to improve the safety of their residents. The program will continue to closely monitor proposed legislation to ensure that existing car occupant and injury prevention legislation remains as is or is strengthened in terms of viability, enforcement, and foreseen outcomes.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	60	65	65	65	60
Annual Indicator	59	53	57.1	57.1	57.1
Numerator					
Denominator					
Data Source		CDC National Immunization Program	CDC National Immunization Program	CDC National Immunization Program	CDC National Immunization Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	60	60	60	60	60

Notes - 2011
Source: 2008 National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services. No new data. Data is given by child's birth cohort. The latest available data is for children born in 2007, Provisional data for the 2008 cohort is not available yet. ywg 5/10/2012.

Notes - 2010
Source: 2008 National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services. Accessed 7/10/2010 from http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm. Data is given by child's birth cohort. The latest available data is for children born in 2007, collected from interviews conducted in 2009. Data for 2010 has not yet been posted.

This rate is for children born in 2007.

Notes - 2009
Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services available at http://www.cdc.gov/breastfeeding/data/NIS_data/2007/state_any.htm.

This rate is for children born in 2007.

a. Last Year's Accomplishments
WIC received $263,224 to continue the Using Loving Support Breastfeeding Peer Counseling Program (BPCP). This program was expanded and administered by the Municipality of Anchorage, Cook Inlet Tribal Council, Resource Center for Parents and Children (RCPC), Southeast Alaska Regional Health Consortium, Alaska Family Services, Bristol Bay Area Health Corporation, and Maniilaq Association. Additionally, the RCPC provides off-site services to rural clients in the Norton Sound and Yukon-Kuskokwim regions of the state.

Breast pump loan programs continued to support WIC clients when a documented need for a breast pump existed. Breast pumps range from manual hand pumps, single-user electric, and multiple-user electric pumps to meet the individual needs of the mothers expressing breast milk.

The University of Alaska-Anchorage (UAA) training program facilitated a breastfeeding list serve for breastfeeding peer counselors, supported the Using Loving Support BPCP as an on-line training, and published a monthly newsletter on breastfeeding that included a continuing education component. The university training program provided Loving Support "Grow and Glow" training to WIC staff this past year.

BCPC managers from across the state continued to hold quarterly teleconferences to discuss programmatic issues, policy development, and targeted education topics.

WIC staff from across the state participated in the annual Alaska Breastfeeding Coalition (ABC) spring conference. The State WIC breastfeeding coordinator continued work with ABC on breastfeeding initiatives.

The State WIC program staff continued to participate on the Alaska Association of WIC Coordinators Breastfeeding Committee and collaborated with the ABC. Alaska WIC continued to collect breastfeeding data and monitor trends through the Alaska WIC Management Information System. Alaska WIC's percentage of breastfeeding duration at 6 months increased to 41% from 40% the previous year.

In August, all WIC offices across the state celebrated World Breastfeeding Week. Bulletin boards and poster and pamphlet templates were developed for all local WIC agencies on breastfeeding resources. A You Tube video was developed using pictures of women giving their advice and thoughts on breastfeeding to mothers contemplating breastfeeding. It can be seen at: http://vimeo.com/29755636.

2008 National Immunization Survey data demonstrated that 57.1% of mothers continued to breastfeed their infants at six-months-old in 2007, an increase from 48.9% the previous year exceeding the national rate.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Maintain the Using Loving Support Breastfeeding Peer Counseling Program			X	X
2. Sustain the WIC breast pump loan program and support services for breastfeeding women		X		
3. Support the Alaska Association of WIC Coordinators Breastfeeding Committee and state agency collaborations				X
4. Continue active participation with the Alaska Breastfeeding Coalition				X
5. Continue data collection and monitoring through PRAMS and Alaska WIC Management Information System				X
6. Work with partners to plan activities to recognize World Breastfeeding Week			X	X
7. WCFH perinatal nurse consultant to provide consultation on breastfeeding issues				X
8. Collaborate with grantees towards the implementation of the Healthy Start and Nurse Family Partnership programs		X		X
9. Establish a designated room for breastfeeding mothers working for the SOA in Anchorage				X
10.				

b. Current Activities
The Using Loving Support BPCP is provided by the same agencies as last year. The RCPC provides off-site services to rural clients in the Yukon-Kuskokwim region. This region is in the process of establishing a BFPCP without the support of the RCPC.

The UAA training program continues to facilitate a list serve for breastfeeding peer counselors, supports the Using Loving Support BPCP as an online training, and publishes a quarterly newsletter on breastfeeding.

WIC BFPC training was offered once to BFPCP managers to help establish and maintain programs that use the Using Loving Support curriculum. Two Alaska state staff and a UAA trainer attended additional BFPC program training to enhance program development. WIC and WCFH staff also participated in the annual ABC spring conference. The State WIC breastfeeding coordinator continues work with ABC on the BCFB initiatives.

WCFH is working to implement the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant. Anchorage is the service area. WCFH is working with a local agency to establish a contract to provide these services. Nurse-Family Partnership (NFP) is the model for this program that emphasizes breastfeeding promotion.
WCFH is working to implement Healthy Start, a program serving high-risk pregnant women and their children. Breastfeeding promotion and support is a program priority. Norton Sound Health Corporation is the grantee and will begin serving clients in 2012.
A new perinatal nurse consultant was also hired.

c. Plan for the Coming Year
The WIC Program will continue to utilize current year activities to support and promote breastfeeding. The goal of the WIC Program is to maintain initiation and duration rates at 6 and 12 months. Current level funding is less than previous awards which will mean less BFPCP support services to women in our state. WIC will continue to have UAA provide quarterly newsletters and teleconferences as educational offerings, in addition to the breastfeeding list serve. There are no plans to provide any face-to-face training at this time. WIC is interested in supporting the SOA breastfeeding workplace policy and wants to identify locations at work for mothers needing to express milk, outreach to women about the policy, and education to State

staff in key positions to implement the policy. WCFH will continue efforts to establish a private, comfortable space for SOA employees who are breastfeeding moms working in the Frontier Building in Anchorage.

During SFY 13, the WIC program will be bringing over a new MIS called SPIRIT. This system will have the capability for BFPC to chart notes on breastfeeding contacts in a specific place in the system and track inventory (breast pumps) and ad hoc reporting capabilities. We are hopeful that these enhanced features will augment our efforts to support statewide breastfeeding rates.

As both MIECHV and Healthy Start programs develop and being to serve clients, breastfeeding initiation and continuation will be a priority. The MIECHV NFP program has a performance measure located in the benchmark plan related to breastfeeding initiation. There will also be a referral mechanism for breastfeeding assistance and support for the mothers if help is needed beyond the nurse home visitor. As a part of the training curriculum for the nurse home visitors, a breastfeeding expert from a local hospital will provide training on breastfeeding for the nurse home visitors. Breastfeeding support and education will continue to be a priority for the Healthy Start project in Nome. Both programs will begin the topic of breastfeeding early in pregnancy to support the IOM recommendations. WIC will be an important referral source for women being served in these programs.

The WCFH perinatal nurse consultant will continue to provide consultation and testify for the legislature, when requested. Breastfeeding promotion will also tie into WCFH's Obesity Initiative which will also include assisting more hospitals to attain Baby Friendly status.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	96	98	100	100	100
Annual Indicator	92.5	94.6	95.3	97.7	97.6
Numerator	10092	10525	10575	10351	10413
Denominator	10916	11120	11100	10596	10673
Data Source		AK Newborn Hearing Screening Program	AK Early Hearing and Detection Intervention Progr	AK Newborn Hearing Screening Program	AK Newborn Hearing Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot					

be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	100	100	100	100	100

Notes - 2010
This is hospital births only.

Notes - 2009
/2011/ There is a data discrepancy for Elemendorf Air Force Base hospital. Without Elmendorf, the hospital screening rate is 98%. Total screening rate for all births is 94%, not including Elemendorf.
/2012/ Provisional data for 2009 updated 6/13/2011.

a. Last Year's Accomplishments
The focus this past year was to increase the number of children tracked successfully through the National 1-3-6 Goals, newborn hearing screening by one month, diagnostic assessment by three months and intervention services by six months, and reduce the number of children lost to follow-up/documentation.

In January 2011, The Early Hearing Detection and Intervention (EHDI) reported data on infants born in CY 2010. In CY 2010, 95% of all infants born in Alaska had newborn hearing screenings and 98.5% of those screened, passed their screening before one month of age. This met the national benchmark. The screening rate for infants born in hospitals was 99%.

Alaska has a 6% out of hospital birth rate and 84% of infants who were not screened were born out of the hospital. The Early Hearing Detection and Intervention (EHDI) Program continued checking a monthly list from the Bureau of Vital Statistics of children born out of hospital. Certified letters were sent to parents of children who did not have a hearing screening. In the first quarter of CY 11, hearing screening equipment was placed at midwifery centers in Juneau and Fairbanks, communities with high out of hospital birth rates.

The EHDI Program continued to send monthly fax reports to birthing facilities to improve follow-up. Letters were sent to parents who had a missed or failed screening and certified letters were sent to the infant's medical home. The program identified populations with the greatest loss to follow-up after a failed newborn hearing screening. One group was children discharged from hub facilities to remote communities. Gift card incentives were purchased for distribution to families of children who return for follow-up. A process for distributing the incentives was developed; however, due to audiology staff changes this program had a slow start.

Another population of children identified in the "lost to follow up program" included those born at the Joint Air Force/Army Hospital. The EHDI Program Manager and Newborn Metabolic Screening (NBMS) Manager met with key personnel at the Joint Air Force/Army Hospital to address the issue of loss to follow-up/loss to documentation. A plan for improvement was initiated.

The EHDI Program continued to meet with the Early Intervention/Infant Learning Program (EI/ILP) to develop a process for receiving named data of children with hearing loss enrolled in intervention services. A separate EI/ILP section of the database was developed to electronically notify the State EHDI Program that a referral was made to early intervention. A referral generated from the database facilitated referrals to EI/ILP by audiology.

The AAP Chapter Champion presented at Pediatric Grand Rounds with a pediatric audiologist highlighting different assistive devices available to young children who are deaf/hard of hearing

and the role of the medical home in advocating for this population.
The Chapter Champion was an active member of the EHDI Advisory Committee which met three times in the past year.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assure accurate and complete utilization of the internet based reporting system through ongoing monitoring of data entry and training of new hospital staff, public health nurses, audiologist, early intervention staff and parent navigators				X
2. Utilize a fax back system with birth screeners to track infants in need of follow-up			X	
3. Continue NICHQ activities to improve the process from screening to diagnosis to intervention services for children in the EHDI system				X
4. Contact parents of infants born out of hospital regarding importance of newborn hearing screening and provide focused education to midwifery centers			X	
5. Monitor the data entry by the audiology community in reporting diagnostic information in the database				X
6. Partner with the Stone Soup Group parent navigators to provide parent-to-parent support and resource information for families of children who are deaf or hard of hearing		X		
7. Collaborate with the Early Intervention/Infant Learning Program to develop a system for identifying and tracking children with hearing loss				X
8. Communicate with outlier communities with implemented UNHS and assure adherence to EHDI protocol and linkages to EI, medical home and audiology			X	
9. Partner with AAP Chapter Champion on EHDI presentations and materials to primary care providers				X
10. Monitor the database for quality assurance and follow-up for children who refer on screening or are diagnosed with hearing loss				X

b. Current Activities
A focus for quality improvement this year is to increase the hearing screening rate for out of hospital births (OOH). Midwifery centers in Juneau and Fairbanks are offering screenings to all OOH births in their community and are reporting in the database.

The OOH screening rate for births in 2011 improved statewide from 38% to 60%. The screening rate for OOH births in the Fairbanks region increased from 39% to 80% and in Juneau from 52% to 92%.

EHDI continues to partner with military facilities to improve tracking of infants from screening through diagnosis. An Air Force commander appointed an ombudsman to review all aspects of the EHDI Program, newborn hearing screening, audiology and pediatrics and develop an operations manual. The military facility took on the process to reconcile their birth log with the EHDI database to identify children loss to follow-up/documentation.

EHDI is partnering with the native health system to improve timeliness of follow-up for children discharged to remote regions of the state.

The EHDI Program is part of a year-long quality improvement program through the National Initiative on Children's Health Care Quality (NICHQ). EHDI is examining all aspects of the system and identifying areas for improvement, such as having audiologists directly contact parents the night before an appointment to improve the "no show" rate by explaining the appointment and improving the manner and type of information shared with parents whose infants do not pass NBHS.

c. Plan for the Coming Year

The EHDI program will continue to focus attention on the National 1-3-6 Goals by addressing children lost to follow-up after initial screening and ensuring children receive timely diagnostic and early intervention services.

The EHDI Program will continue to partner with EI/ILP to track children from diagnosis to intervention services. This will assist both programs in identifying issues related to loss to follow-up and improve early referrals for intervention after diagnosis.

The EHDI Program will collaborate with the Alaska Native Medical Center (ANMC) and regional hubs to develop protocols to address loss to follow-up for specific regions. Change in the rate of loss to follow-up after screening will be tracked.

EHDI will monitor the change in the rate of OOH births that receive newborn hearing screenings, and explore new opportunities for educating midwives on the benefits of newborn hearing screening.

The EHDI Program will continue to work with military facilities to improve tracking of infants from screening through diagnosis, data reporting to EHDI Program and implementation of the operations manual.

Opportunities to engage the medical home, including providing Just in Time materials and the participation of the AAP Chapter Champion will be explored. Utilization of a fax alert to primary care providers will be trialed. The EHDI Program Manager and the Newborn Metabolic Screening Manager will collaborate on opportunities for providing updates, data and highlighting program improvements.

Improving parent support to parents of children diagnosed deaf or hard of hearing will be ongoing. Opportunities for introducing the parent navigator to families will be explored. A small group of parents and other stakeholders will look at financial issues for families who need assistance with accessing screening and diagnostics. An updated calendar distributed by hospitals and birthing centers for all parents of newborns will provide developmental information to parents.

The EHDI Program will complete its participation in the Improving Hearing Screening and Intervention Systems (IHSIS) led by the NICHQ. The team, consisting of the EHDI Program Manager, pediatric audiologist, parent navigator and early interventionist will present its finding to a larger stakeholder team and prioritize ongoing improvement activities

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011

Annual Performance Objective	9	8.5	8.5	8.5	10.5
Annual Indicator	11.2	13.2	12.4	12	
Numerator	21501	25600	24100		
Denominator	192254	193600	194300		
Data Source		Kaiser Family Foundation	Kaiser Family Foundation	Kaiser Family Foundation	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	10.5	10.5	10.5	10.5	10.5

Notes - 2011
2010 is the latest available data.

Notes - 2010
Source: Henry Kaiser Family Foundation, State Health Facts online, Alaska: Health Insurance Coverage of Children 0 - 18, states (2008-2009). Based on American Community Survey. Numerators and denominators were not reported. Retrieved 5/10/2012 from http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi.

Notes - 2009
2009 is the latest available data. Numerator is the number of children under 18 in the State who are not covered by any private or public health insurance (Including Medicaid or risk pools) at some time during the reporting year.

a. Last Year's Accomplishments
In December 2010 (FFY 11, Qtr 1), the Department received its second CHIPRA performance bonus payment for eligibility simplification and enrollment gains for children enrolled in Medicaid.

The CHIPRA quality improvement state grant awards were issued for the T-CHIC, a tri-state partnership, in July 2011 (SFY 12). The initial planning phase with state grantees and other in-state non-grantee partners began in July 2011 to improve the quality of children's health care through children's quality measurement, to enhance care coordination and to evaluate patient centered medical homes.

CHIPRA allotment funding was rebased for the first time in 2011. Child enrollment and renewal simplifications were supported adequately to increase enrollment and corresponding child health expenditures in 2010. Rebasing under CHIPRA was directly linked to FFY 2010 child health expenditures. Enrollment gains of eligible children from streamlining and simplification were achieved and the veto of the child expansion did not adversely impact rebasing under CHIPRA.

The MCH Title V/CSHCN Director focused attention on work with Medicaid/CHIP and helped assure that both programs were more effectively meeting the requirements for outreach and education around EPSDT services and Medicaid coverage. Work was begun on the development of joint educational sessions for health care providers related to EPSDT and developmental

screening in support of the ABCD program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with staff from MCH Title V, Rural Health, Medicaid, Public Health Nursing and the Commissioner's office to work through the challenges in outreach, enrollment and participation for EPSDT				X
2. Respond to requests for information related to Denali KidCare legislation				X
3. Participate with Regional Tribal Health Centers to conduct administrative activities to ensure efficient and effective administration of the Medicaid enrollment program				X
4. Work with advocacy groups to encourage action on the part of the legislature to raise the eligibility level for CHIP to 200% of FPG				X
5. Title V staff will continue to participate in the redesign and implementation of the new Medicaid Management Information System to assure capacity for new programs, appropriate activities supporting EPSDT, and ease of data tracking for analysis				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Two in-state grantees were awarded under the CHIPRA T-CHIC grant with OR and WV. They are Southcentral Foundation and Peninsula Community Health Services. They join Illiuliuk Family Health Services which had been funded already. WCFH has a HRSA funded pediatric medical home care coordination grant and worked with T-CHIC project staff to support the federal grant's goals and objectives.

The WCFH CSHCN staff coordinated with Medicaid/CHIP staff to assure both programs meet requirements for outreach and education around EPSDT services and Medicaid coverage. Initial work was done on developmental screening policy under EPSDT to support reliable measurement of the developmental screening children's measure. This is a core CHIPRA children's quality metric to meet NQF standards and to support ABCD efforts. Title V, Medicaid/CHIP, and others continued to work with the Child and Adolescent Health Measurement Initiative at Oregon Health Sciences University through our T-CHIC project to implement the policies and procedures to effectively collect and measure data related to the CHIPRA core children's quality measures.

Bright Futures guidelines were adopted in regulation to serve as the framework for timing and content for EPSDT Medicaid well child visits. Promotion of the use of these materials began through presentations at pediatric grand rounds, provider notices in the Medicaid notification process, and through a weekly electronic newsletter sponsored by the Alaska chapter of AAP.

c. Plan for the Coming Year

It is likely that the Department will again qualify for its fourth CHIPRA performance bonus payment, which is expected to be received in 1st Quarter FFY 13, December 2012

It is anticipated that the MCH HRSA pediatric medical home care coordination grant and the T-CHIC CHIPRA AK pilot projects will continue their collaborative work on care coordination begun in 2012. It is hoped that the process improvements related to PCMH, children's quality measures and associated HIT advancements will be shared with other pediatric providers/stakeholders through additional learning collaborative workshops.

The MCH Title V/CSHCN Director and staff members will continue to focus attention in working with the Medicaid/CHIP and assuring that both programs are more effectively meeting the requirements for outreach and education around EPSDT services and Medicaid coverage. In addition Title V, ILP, ECCS and Medicaid/CHIP will continue to work with the Child and Adolescent Health Measurement Initiative (CAHMI) at Oregon Health Sciences University through our T-CHIC project (CAHMI is a partner to Oregon and collaborates with AK and WV) to implement the policies and procedures necessary to effectively collect and measure the CHIPRA core children's quality measures including child developmental screening measure, at both the state level and practice levels. Funds from the Alaska Mental Health Board were approved by the legislature for the SFY13 budget and will be transferred to the Office of Children's Services to educate and promote the use of standardized developmental screening tools with an emphasis on screening for social/emotional health using the ASQ-SE. Health care providers cannot access the tools online sponsored by the early intervention program. This has lead to many providers enrolling in this feature and greater use of the on-line tools. MCH Title V/CYSHCN will do an additional distribution of Bright Future's guidebooks and ASQ tool kits to interested providers in the coming year.

In addition federal dollars from the HRSA pediatric medical home care coordination grant will be utilized to sponsor hands on care coordination training in September taught by Dr. Antonelli, one of the project team members who developed the curriculum funded by the MCHB Family Voices Cooperative Agreement.

Title V dollars will continue to provide gap-filling services in the area of pediatric specialties including genetics and metabolic clinics, neurodevelopment/autism screening services, cleft lip and palate assessment and evaluation, neurology services, and parent navigation. Reproductive health services for young women and teens will be provided using Title V dollars. While some Medicaid reimbursement is available, it covers only part of the costs of these services.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	21.5	21	20.5	20	20
Annual Indicator	21.6	21.5	21.7	21.5	21.4
Numerator	3371	3374	3571	3718	3469
Denominator	15579	15662	16462	17273	16192
Data Source		WIC program, Report #340.	WIC program, Report #340	WIC program, Report #340.	WIC program, Report #340.
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	20	20	20	20	20

Notes - 2010
Data covers children 2-4 years, 5 year olds are not included because they are not part of the WIC program. The indicator measures children with a BMI at or above the 95th percentile. AK does not collect data on 85th %-ile. Note that growth curves for Alaska Native children may not be the same as for caucasian children.

Notes - 2009
2011/ Source: WIC program, Report #340. Data covers children 2-4 years, 5 year olds are not included because they are not part of the WIC program. The indicator measures children with a BMI at or above the 95th percentile. AK does not collect data on 85th %-ile. Note that growth curves for Alaska Native children may not be the same as for caucasian children.

a. Last Year's Accomplishments
Alaska's Women, Infants and Children (WIC) program rates for overweight children decreased slightly from 21.52% in 2010 to 21.42% in 2011. The indicator measured children ages 2-5 years at or above the 95th percentile. The Family Nutrition Program's strategic plan (http://www.hss.state.ak.us/dpa/programs/nutri/downloads/200705_strategicreport.pdf) continued to include obesity prevention in all WIC grantees' requests for proposals. The federal WIC program data collection measures do not include the collection of data at the 85% percentile.

Sixteen Alaska WIC local agency grantees continued to include the goal of reducing the prevalence of overweight and obesity among Alaskan children and adolescents in their nutrition education and services plans. They continued implementing Alaska WIC's nutrition themes: "Family Meals and Breastfeeding…So Good For Me," "Playtime…. So Good For Me" and "Water, Water… So Good for Me!" in outreach and other program activities. Nutrition education WIC funds were used to provide nutrition theme materials to local agencies. Those materials are available on the Division of Public Assistance's Family Nutrition, WIC-Nutrition Education website: http://www.hss.state.ak.us/dpa/programs/nutri/WIC/WICEducation.htm. Dissemination of nutrition theme materials also continued through the State Nutrition Action Plan (SNAP) Committee's program activities.

Changes to the WIC food package during SFY 2011 continued to help WIC families eat more nutritious meals regularly while also fostering a life-long consumption of healthy foods. In SFY 2011, WIC once again offered Farmers' Market coupons to purchase produce grown locally in various parts of the state. Farmers and farm markets in areas such as Bethel and Dillingham were actively involved in providing healthy, local produce to WIC participants. Continued training on nutrition assessment and participant-centered education helps support the WIC program's initiatives to reduce overweight and obesity among Alaskan children and adolescents. WIC implemented and utilized Alaska WIC nutrition reports for quality assurance, program planning and to identify coordinated national objectives that promote healthy eating and active lifestyles.

Also during 2011, WIC's strategic plan was revised, with its core purpose defined around providing quality nutrition education and food. The long term goal is no increase in percentage of

obese WIC kids across Alaska.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Adapt participant-centered education model training and implementation			X	
2. Use WIC nutrition reports for quality assurance/program planning			X	
3. Identify coordinated objectives to promote healthy eating and active lifestyles			X	
4. Disseminate nutrition themes via SNAP			X	
5. Incorporate revised strategic plan's purpose and goals into local area WIC grants				X
6. Share WIC data with DPA				X
7.				
8.				
9.				
10.				

b. Current Activities

Alaska staff continues to train on the participant-centered education model as the State's adapted method to provide services to all WIC clients during SFY 2012. Additionally, WIC breastfeeding peer counseling (BFPC) programs were expanded and training for BFPC staff occurred twice during the fiscal year to support clinic staff in providing evidence-based breastfeeding promotion and support to help reduce overweight and obesity in children. Clinic staff members continue to access WIC nutrition reports for quality assurance and program planning efforts. Obesity rates are monitored on a monthly basis and program efforts and resources are directed accordingly. In an effort to share data and help bring awareness to the obesity issue in Alaska, WIC started sharing data with the Division of Public Assistance (DPA). This information is also published on the website for the general public to view.

The WIC nutrition themes are being expanded to include a fourth, "Fruits and Vegetables…. So Good for Me," following the same format which includes posters, brochures, talking points for counselors, and other incentive items.

Our current WIC Nutrition Coordinator position has been vacant for eight months. The State hopes to fill this position in SFY 13.

c. Plan for the Coming Year

Next year Alaska WIC local agency grantees will continue to infuse the goal of reducing prevalence of overweight and obesity among Alaskan children and pregnant adolescents in their nutrition education and service plans. Local agency grantees will incorporate all four nutrition themes and the revised WIC strategic plan while providing their clients' counseling and education.

Participant-centered education will be used to engage participants in setting their own nutrition goals and encouraging them to incorporate WIC foods into their daily meals. Obesity trends will be monitored and used for program planning. Data will continue to be shared with our DPA partners and documented on the DPA website.

Alaska will implement updated nutrition risks criteria, per a USDA mandate during SFY 2013.

Alaska will adopt the "At Risk of Overweight" nutrition risk criteria. The USDA risk criteria will include a weight-related risk that covers infants and children less than 24 months, "High Weight-for-Length (Infants and Children < 24 Months of Age)," which Alaska will also implement. Both risk criteria will help WIC identify, educate and track data specific to overweight and obesity in Alaska. Identifying children at younger ages supports the program's overall goal to reduce overweight and obesity in children.

The current WIC computer system is slated for replacement in January 2013. The new system will continue to capture trend data on overweight and obesity and will lend itself to more flexible reporting functionality. This will assist the Alaska WIC program in planning and assessing existing efforts to address overweight and obesity concerns in Alaska. This coming year will focus on transferring data to the new WIC computer system while making changes to the program to meet Alaska's needs. Complete implementation will occur by March 2013.

Wherever possible, the program plans to expand Farmers' Market programming and provide WIC coupons to rural regions in the state. The State has identified potential markets in the Bristol Bay region, for example, with Dillingham farmers sending produce to villages such as Togiak, Twin Hill and Manokotak.

The State looks forward to having a WIC Nutrition Coordinator position filled during SFY 13 to facilitate these activities and advance on the goal to reduce childhood obesity in Alaska.

The Section of Women's, Children's and Family Health (WCFH) will lead a section workgroup on efforts to prevent and reduce the burden of obesity throughout the life course. They will address healthy pregnancy weight in their Healthy Start and MIECHV grants they administer, which includes a focus on breastfeeding promotion and nutrition for toddlers.

WCFH staff will be active in the Alaska Breastfeeding Coalition and will collaborate with WIC to support breastfeeding and reduce obesity.

WCFH will continue efforts to establish a space for breastfeeding moms who working in the Anchorage Frontier Building.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	15	13.5	13.5	13.5	14.5
Annual Indicator	15.5	15.0	15.3	16.8	
Numerator	1645	1637	1672	1853	
Denominator	10613	10879	10910	11036	
Data Source		Alaska PRAMS	Alaska PRAMS	PRAMS	PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

	2012	2013	2014	2015	2016
Annual Performance Objective	14.5	14.5	14.5	14.5	14.5

Notes - 2011
Data for 2011 is not yet available.

Notes - 2010
Data for 2011 is not yet available.

Notes - 2009
Source: Alaska PRAMS

The latest data available is for CY 2008.

a. Last Year's Accomplishments
The life course framework is used to organize work in the perinatal health program. Primary prevention and its power to improve birth outcomes and life's trajectory is the program's focus, and well suited to the issue of tobacco use during pregnancy.

Materials related to tobacco use and cessation during pregnancy were distributed. This included our Maternal and Child Health Data Books, pamphlets and flyers. The supply of Healthy Mother, Healthy Baby Diaries, which contained tobacco content, ran out and efforts continued to find a replacement product in lieu of doing the extensive work required to edit and reprint. A new list serve format was put in place to increase visibility and reach, and was used to distributed tobacco-related information. The text4baby service has been promoted to the largest wireless carriers in Alaska, but their response has been lackluster.

WCFH collaborated with the Section of Chronic Disease Prevention's tobacco program on development of a tobacco and pregnancy information sheet. Free and Clear again provided Alaska Quit Line services through a contract with the tobacco program, offering intensive follow-up for pregnant smokers. They use specific protocols and training for use with pregnant callers to enhance counseling for pregnant women. This includes Alaska-specific training related to chew tobacco, including iqmik. The consultant supported the Alaska Quit Line through education and referral efforts.

The major focus for perinatal health this year was completion of the grant processes for two programs designed, among other things, to increase enrollment in early prenatal care. The MIECHV grant application, including a needs assessment and updated state plan were submitted. A Healthy Start grant application was also submitted.

The Alaska Infant Safe Sleep Initiative, with the role tobacco plays in infant sleep-related death, addressed the importance of including tobacco in whatever social marketing messages and materials are ultimately developed.

The Section of WCFH and Alaska Native Tribal Health Consortium (ANTHC) coordinated the three-day Alaska MCH and Immunization Conference in September 2010. Many topics relevant to prenatal care were included such as prenatal alcohol and tobacco exposure and cessation.

In 2010, 16.8% of women report smoking in the last three months of pregnancy, compared to 15.3% for 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Distribute provider and consumer education materials on tobacco and pregnancy			X	
2. Collaborate with tobacco program on projects related to tobacco cessation education for pregnant women and their health care providers				X
3. Address the role of tobacco in infant sleep-related deaths via the infant safe sleep initiative				X
4. Continue to provide expanded and specialized Alaska Quit Line services for pregnant women			X	X
5. Continued implementation of the Healthy Start and MIECHV programs		X		X
6. Plan and hold Alaska MCH and Immunization Conference in September 2012				X
7.				
8.				
9.				
10.				

b. Current Activities
Work from last year continues, including distribution of materials in various formats. The new list serve format which began with about 130 subscribers has grown to almost 500. The perinatal nurse consultants are in the process of reviewing and updating the content of the perinatal health program website which includes resources on tobacco cessation. WCFH selected "Baby and Me," a book which contains tobacco content, to replace the Healthy Mother, Healthy Baby Diary. A large order has been placed.

WCFH was given permission to implement the MIECHV program and awarded a grant to implement the Healthy Start program. Both programs will screen for tobacco use and promote tobacco and cessation. A performance measure on this has been included in the benchmark plans.

A second perinatal nurse consultant was hired this year. She manages the MIECHV grant, as well as addressing other perinatal issues such as tobacco.

Based on work done by WCFH's Alaska Infant Safe Sleep Initiative, DPH issued a position statement on safe sleep which included the statement that babies should be tobacco-free before and after birth. Staff presented this information at pediatric grand rounds, the Alaska Public Health Nursing Conference, and for other community organizations.

WCFH is collaborating with ANTHC to put on the Alaska MCH and Immunization Conference in September 2012.A perinatal nurse consultant is leading planning of the perinatal track which contains sessions related to tobacco.

c. Plan for the Coming Year
WCFH will update its perinatal data base and widely distribute "Baby and Me" to facilities that serve pregnant women across Alaska. The perinatal nurse consultants will continue to pursue text4baby, which includes tobacco-related messages, for Alaska. Two of Alaska's largest wireless carriers, GCI and ACS, have recently announced a merger and WCFH will attempt to engage this entity to support text4baby.

The perinatal nurse consultants will work to increase collaboration between the tobacco program and perinatal health program on a variety of levels which include: distribution of tobacco cessation materials, asking the tobacco program for a staff person to sit on the perinatal and

home visiting advisory committees, asking for a perinatal nurse consultant to serve on a committee the tobacco program leads, and working with the tobacco program to develop a rack card to promote the Alaska Quit Line's pregnant caller services. A representative from the Alaska Tobacco Quit Line will also be presenting at a WCFH staff meeting this fiscal year.

Work will continue on implementing the Healthy Start and MIECHV programs. Perinatal staff will work to ensure the tobacco program has an actively participating member on the state home visiting advisory committee who can be consulted regarding tobacco issues relevant to home visiting. A mental health clinician from the Alaska Division of Behavioral Health will be included in the nurse home visitor training as a speaker on substance abuse (including tobacco) during pregnancy. Benchmark data on prenatal smoking status will also be evaluated as a part of quality assurance.

The Alaska Infant Safe Sleep Initiative will be moving into a more active phase of message selection and product development for the social marketing campaign. The critical role tobacco plays in the risk of infant sleep-related death will be included in any social marketing materials.

Other possibilities include working with ATCA on a PSA addressing pregnant women and tobacco and exploring the prospect of having a perinatal program Facebook page.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	30	27	27	27	22
Annual Indicator	22.9	26.5	24.2	28.6	
Numerator	38	44	40	46	
Denominator	166142	166110	165615	160671	
Data Source		Alaska Bureau of Vital Statistics	Alaska Bureau of Vital StatisticsAlaska Bureau of	StatisticsAlaska Bureau of	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	22	22	22	22	22

Notes - 2011
Source: Alaska Bureau of Vital Statistics. The most recent data available is 2008 - 2010. This indicator is reported by 3-year moving averages.

Notes - 2010
Source: Alaska Bureau of Vital Statistics. The most recent data available is 2008 - 2010. This indicator is reported by 3-year moving averages.

Notes - 2009
Source: Alaska Bureau of Vital Statistics. The most recent data available is 2007 - 2009. This indicator is reported by 3-year moving averages.

a. Last Year's Accomplishments
In FY11, the Division of Behavioral Health's (DBH) Comprehensive Behavioral Health Prevention & Early Intervention Services (CBHPEIS) Program completed its final year of a three-year grant cycle. Approximately fifty grantees, including sixteen community-based suicide prevention grantees, were funded throughout Alaska. Grantees employed prevention strategies that were designed to create a long-term impact in reducing the harmful effects of drugs and alcohol, increase resiliency and community wellness, and reduce suicide.

Grantee organizations ran a variety of youth, adult and community prevention and early intervention programs. Examples included healthy recreation programs, teen centers, sports activities, mentoring, and cultural activities, e.g., subsistence, beading, carving, drumming, and Alaska Native and Eskimo dance. Grantees employed strategic prevention planning methods with support and technical assistance from the project and program coordinators within their communities/regions to use evidence-based prevention strategies and build culturally responsive and sustainable practices.

As a result of the grant period, accomplishments were enhanced integrating suicide prevention programs with other behavioral health prevention strategies, activities and services. Short term outcomes showed increases in protective factors such as social/emotional skills development, family, school and community connectedness, meaningful activities, cultural knowledge and practices, and identity development. Focus on reduction of risk factors including drug, tobacco and alcohol use, problems associated with depression, bullying, lack of family and community engagement, social isolation and self-destructive behaviors.

DBH was also awarded a "no-cost" extension to continue the Substance Abuse and Mental Health Services Administration (SAMHSA), Garett Lee Smith youth suicide prevention grant. This will be the final year of the Alaska Youth Suicide Prevention Project. The three regional suicide prevention teams were located in: 1) Fairbanks region, 2) urban and rural communities throughout Southeast Alaska and 3) the Lower Kuskokwim villages of Akiak, Akiachak, Kwethluk and Tuluksak. Strategic plans were implemented including early prevention, intervention and post-intervention strategies to reduce suicide among youth ages 15-24 years of age.

Among these strategies, hundreds of people were trained in the Alaska Gatekeeper Suicide Prevention Training throughout the state, implementation of broad based media campaigns e.g. "1 is 2 Many" which included radio and television PSAs, use of web-based social media and print advertising and promotion of local and statewide crisis call centers. In addition, direct services were also offered to those most vulnerable to suicide risk. Screening, identification, referral and counseling were offered to youth less likely to receive services through traditional means.

DBH also developed a postvention resource guide and toolkit which included a suicide survivor resource packet. DBH hosted a statewide postvention training and healing conference in June of 2011 which was attended by approximately 80 people. Evaluations were positive, showing that postvention resources (i.e., materials, trainings and technical assistance) are strongly needed

throughout the state.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide for community-based suicide prevention grants			X	X
2. Develop a statewide mechanism for delivery of the Alaska Gatekeeper suicide prevention training curriculum				X
3. Promote the use of the evidence-based youth suicide prevention program				X
4. Participate and present at a number of statewide conferences				X
5. Disseminate Alaska Suicide Prevention Plan and Alaska Postvention Resource Guide				X
6. Implement SAMHSA Alaska Youth Suicide Prevention Project (3-year grant project)		X	X	X
7. Develop postvention resources and provide for technical assistance and training				X
8.				
9.				
10.				

b. Current Activities

DBH is completing its final year with the SAMHSA youth suicide prevention grant. The Alaska Youth Suicide Prevention Project is implementing their regional strategic plan and sharing resources and services to address community suicide prevention needs. Sustainability plans include further expansion of trainings, enhanced suicide prevention awareness campaigns, coordination with the state for development of community postvention planning and survivor outreach supports, and increased linkages and access to services. This includes promotion of Careline, Alaska's only statewide crisis call center. Careline had recently released a new texting option to increase outreach efforts to vulnerable teens.

DBH started its first year of its three-year CBHPEIS grant. Changes to the on-going program included awards to well developed proposals that will have a higher likelihood of achieving significant prevention outcomes for Alaska communities. A stronger focus on population level outcomes will be reinforced throughout the term of the grant.

DBH also participates in an annual School Health and Wellness Institute, which provides suicide prevention training and information to statewide school staff. The Alaska State Legislature recently passed legislation which mandates school educators to receive a minimum of two hours of suicide prevention training. This will allow DBH to develop and expand the delivery of the Alaska Gatekeeper suicide prevention training curriculum and other trainings.

c. Plan for the Coming Year

FY13 will see some new developments as well as continued enhancements to Alaska's suicide prevention resource infrastructure. The recent legislation will deliver anticipated suicide prevention training to all middle and high schools statewide. These trainings will be coordinated by the Department of Education and Early Development. This will allow for stronger coordination with Alaska school districts throughout the state.

Although DBH is completing its final year with the SAMHSA grant, The Alaska Youth Suicide Prevention Project may receive continued funding. The Division has received notice that the

Alaska DBH Garrett Lee Smith grant proposal is being re-considered for the FY 2014-2017 federal grant cycle. The program would shift resources exclusively towards suicide prevention training and technical assistance to communities. This will allow increased capacity for agencies, groups and coalitions that have been newly formed or who are currently working to enhance community based-trainings.

In the second year of the Comprehensive, Behavioral Health, Prevention and Early Intervention Services grant program, DBH will continue to build capacity for Alaska's suicide prevention projects, and more individualized training and technical assistance to improve the community planning process and increase successful outcomes. As the prevention grant program narrows focus on outcomes, it will require grantees to make stronger connections between strategies and expected results. Grantees will receive stronger technical assistance to better prescribe evaluation plans that target community and population level outcomes. This will help to ensure cultural responsiveness and longer term sustainability beyond grant funding.

Other DBH related projects include continued work on the FY13 postvention project. The project for this year will consist of 1) training the trainer model utilizing a postvention best-practice Connect Postvention Training, 2) enhanced postvention resource guide and survivor of suicide loss materials. DBH also plans to solicit a statewide contract for training and technical assistance to help support communities in developing these resources locally.

As in previous years, the DBH will continue to place emphasis on capacity development including its partnership with the Statewide Suicide Prevention Council. This will enhance state and tribal health system coordination, public information campaigns and efforts to implement evidence-based and best practice models in schools and other youth organizations. Other partnerships include the Alaska Native Tribal Health Consortium to expand culturally responsive projects and services. The statewide suicide prevention web-portal www.stopsuicidealaska.org will continue development and will be used as an on-going resource to strengthen statewide coordination. This supports the idea that everyone is working together to reduce and stop suicide in Alaska.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	82	84	86	86	86
Annual Indicator	76.8	71.1	75.9	79.0	
Numerator	76	81	85	83	
Denominator	99	114	112	105	
Data Source		Alaska Bureau of Vital Statistics	Alaska Bureau of Vital Statistics	Alaska Bureau of Vital Statistics	Alaska Bureau of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	90	90	90	90	90

Notes - 2011
Source: AK Bureau of Vital Statistics. CY 2010 is most recent data available.

Notes - 2010
Source: AK Bureau of Vital Statistics. CY 2010 is most recent data available.

Notes - 2009
Source: AK Bureau of Vital Statistics. CY 2009 is most recent data available.

a. Last Year's Accomplishments
The perinatal nurse consultant distributed materials, helped plan and conduct professional education activities, and participated in partnerships that promoted improved birth outcomes, generally. A new listserv was put in place to increase visibility and reach. The perinatal nurse consultant continued to collaborate with March of Dimes (MOD) and supported their work and that of other agencies and facilities.

In September 2010 WCFH and Alaska Native Tribal Health Consortium (ANTHC) partnered to hold a 3-day MCH conference that included a popular session on stabilizing the pregnant women for transport to promote delivery of high-risk pregnancies at Alaska's level III NICU. Also included were sessions related to prematurity and low birthweight such as prenatal alcohol and tobacco exposure and cessation, and domestic violence and their implications for low birthweight and other perinatal problems.

Following an earlier presentation and follow-up discussions on CenteringPregnancy, Providence Family Medicine Clinic and its family medicine residency program decided to implement the CenteringPregnancy model. They arranged provider training and along with several other practices including those from rural Alaska, completed a workshop in April 2011. CenteringPregnancy promotes improved perinatal outcomes, in general.

The major focus for perinatal health this year was completion of the grant processes for two programs designed improve perinatal outcomes, including low birth weight. The MIECHV grant application, including a needs assessment and updated state plan were submitted. A Healthy Start grant application was also submitted.

In 2010 79.0% of low birthweight babies were born at The Children's Hospital at Providence, which has Alaska's only Level III NICU, up from 75.9% in 2009. Again, this falls far short of the 90% goal.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to distribute information on prevention of low birthweight via various forms of communication				X
2. Include the issue of transport of VLBW babies in Healthy Start project in Nome				X
3. Support March of Dimes efforts and serve on the program services committee and 39 Weeks committee				X
4. Conduct MCH outcome data analyses and update MCH				X

publications, including the MCH Data Books				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The perinatal nurse consultant will continue to distribute perinatal materials in a variety of ways. The new list serve grew from about 130 subscriptions to 500. Staff is updating the content of the perinatal health program website. A comprehensive prenatal/newborn resource for parents, "Baby and Me," was recently ordered. It addresses low birth weight among other topics.

WCFH was given permission to implement the MIECHV program, and awarded a grant to implement the Healthy Start program. MIECHV will use the Nurse-Family Partnership model to serve pregnant women in Anchorage. Healthy Start will serve pregnant women in Nome. A new perinatal nurse consultant was hired to manage the MIECHV grant and address a number of other perinatal issues.

The addition of a new position will allow more attention than in the past to be given to the specifics of the birth of very low birthweight babies in tertiary hospitals that this performance measure addresses. The Healthy Start project in Nome will be an appropriate place to begin to focus on transporting pregnant women to the level III NICU for delivery.

Staff continues on the MOD Program Services Committee and collaborates on the 39 Weeks campaign to reduce late preterm and near term births, especially elective inductions. This includes working with the All-Alaska Pediatric Partnership, publishing a statewide epidemiology bulletin, and doing OB grand rounds.

c. Plan for the Coming Year

The coming year will bring new opportunities to address the issue to very low birth weight babies and the location of their birth. This aspect will be incorporated into the Healthy Start project in Nome, which can perhaps serve as a pilot for expansion of efforts elsewhere in the state.

Unable to complete this last year, as planned, WCFH will conduct outcome data analyses to more thoroughly elucidating where very low birthweight babies are born when they aren't born at the tertiary care hospital. This information is needed to more fully understand and address the issue.

The perinatal nurse consultants will resurrect the perinatal advisory committee with a half-day meeting this October. Transport of very low birthweight babies may be the topic of a future meeting.

Other possible future activities include:

Explore options for partnering with All-Alaska Pediatric Partnership to improve transport rate.

Contact MCH case managers at ANTHC to discuss their policies.

Meet with managers at The Children's Hospital at Providence to discuss the possibility of establishing a rural-urban nurse exchange program to help build bridges between health care facilities, improve standards of care and birth outcomes, especially for low birthweight and preterm infants.

Look into the possibility of supporting the Perinatal Continuing Education Program in rural areas.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	85	85	85	85	85
Annual Indicator	80.3	79.8	80.3	78.7	
Numerator	8584	8716	8290	8323	
Denominator	10689	10922	10321	10571	
Data Source		Alaska Bureau of Vital Statistics	Alaska Bureau of Vital Statistics	Alaska Bureau of Vital Statistics	Source: AK Bureau of Vital Statistics.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	85	85	85	85	85

Notes - 2011
Source: AK Bureau of Vital Statistics. CY 2010 is most recent data available

Notes - 2010
Source: AK Bureau of Vital Statistics. CY 2010 is most recent data available.

Notes - 2009
Source: AK Bureau of Vital Statistics. CY 2009 is most recent data available.

a. Last Year's Accomplishments
The life course framework is used to organize work in the perinatal health program. Primary prevention and its power to improve birth outcomes and life's trajectory is the program's focus.

A number of activities address prenatal care generally. Information for providers and consumers of perinatal care, including evidence-based programs, professional education opportunities, and health education, was distributed to a variety of facilities throughout the state via personal delivery, mail, and electronically. A new list serve format was put in place. The text4baby service has been promoted to the largest wireless carriers in Alaska, but their response has been lackluster. The supply of Healthy Mother, Healthy Baby Diaries ran out but still time was not

available to do the extensive work required prior to reprinting.

The PRAMS data continued to be a rich source of information about prenatal health and the MCH Epi Unit continued to conduct outcome data analyses and update MCH publications. These were also distributed.

The Section of WCFH and Alaska Native Tribal Health Consortium (ANTHC) held the three-day Alaska MCH and Immunization Conference in September 2010. Many topics relevant to early prenatal care were included, such as prenatal alcohol and tobacco exposure and cessation, domestic violence, maternal depression, and cultural and linguistic competence.

Subsequent to past PAC presentations, Providence Family Medicine Clinic decided to implement the CenteringPregnancy model. Other providers became interested, as well, and arranged for a provider training workshop to be held in April.

The perinatal nurse consultant supported March of Dimes (MOD) and held membership on the program services committee. WCFH collaborated with the tobacco program on a tobacco and pregnancy information sheet and distributed it and other materials. She also supported other agencies and individuals in their requests for technical assistance.

The major activity for perinatal health this year was completion of the grant processes for two programs designed, among other things, to increase enrollment in early prenatal care. The MIECHV grant application, including a needs assessment and updated state plan were submitted. A Healthy Start grant application was also submitted.

The section supported state legislative efforts, as requested, to increase the eligibility for Alaska's CHIP for pregnant women. Despite overwhelming popular and legislative support, Alaska's Governor vetoed a bill to increase access to Alaska's CHIP, Denali KidCare.

A bill to increase access to Denali KidCare failed in the legislature again this year, because of concerns related to funding abortion.

Infants born to pregnant women who received prenatal care during their first trimester was 78.7 for 2010, compared to 80.3% for 2009 and 79.8% for 2008.We have not had improvement in over 10 years in the percent of infants born to women beginning prenatal care in the first trimester, and in some areas of the state fewer than 55% of pregnant women begin prenatal care in the first trimester, such as in the Wade Hampton area of Southwest Alaska.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Convene perinatal advisory committee on a regular basis and spotlight key perinatal programs and issues				X
2. Support March of Dimes, Providence Alaska Medical Center, and other individuals and organizations to improve perinatal outcomes				X
3. Distribute provider and consumer perinatal education materials			X	X
4. Conduct joint MCH conference in September 2010, including topics with implications for early prenatal care				X
5. Conduct MCH outcome data analyses and update MCH publications				X
6. Begin implementing Healthy Start and MIECHV grant		X		X

programs				
7.				
8.				
9.				
10.				

b. Current Activities

General activities from last year continue. The new list serve grew from about 130 subscriptions to 500. Staff is in the process of reviewing and updating the content of the perinatal health program website. A decision was made to select a comprehensive prenatal/newborn resource for parents, instead of revising the Healthy Mother, Healthy Baby Diary. "Baby and Me," was selected following an exhaustive review and a large order was recently placed.

WCFH is collaborating with ANTHC to put on the Alaska MCH and Immunization Conference in September 2012.A perinatal nurse consultant is leading planning of the perinatal track.

Staff continues on the MOD Program Services Committee and collaborates on the 39 Weeks campaign. This includes works with the All-Alaska Pediatric Partnership and doing OB grand rounds.

WCFH was given permission to implement the MIECHV program, and awarded a grant to implement the Healthy Start program. MIECHV will use the Nurse-Family Partnership model to serve pregnant women in Anchorage. Healthy Start will serve pregnant women in Nome. A new perinatal nurse consultant was hired to manage the MIECHV grant and address a number of other perinatal issues.

The section continues to discuss the life course perspective and how this approach might be operationalized to guide our work in improving women's health and associated perinatal outcomes.

A resolution to declare March Congenital CMV Prevention Month passed in the legislature. Technical assistance was provided.

c. Plan for the Coming Year

The perinatal nurse consultants will continue to distribute perinatal materials in a variety of ways. They will do a mass distribution of the "Baby and Me" book. Staff will continue to pursue text4baby for Alaska. The process for establishing a Facebook page on perinatal health will be started. Staff will continue to collaborate with MOD on projects of mutual interest. The popular Alaska folic acid pamphlet that was originally developed jointly with MOD is due to be revised and reprinted and would be a fitting collaborative project.

The perinatal nurse consultants will resurrect the perinatal advisory committee with a half-day meeting this October. The life course approach will likely be a topic of this meeting, along with perinatal immunizations and a report from our Alaska Birth Defects Registry.

Work will continue on the MIECHV and Healthy Start grants this year. The Section is currently negotiating a contract with an organization in Anchorage to implement the Nurse-Family Partnership program. Norton Sound Health Corporation in Nome is beginning to get the Healthy Start project underway. It is hoped both programs will be providing services to clients in September.

The Alaska MCH and Immunization Conference will be held in September 2012. Topics will include prematurity, perinatal immunization, substance use in pregnancy, and weight gain during pregnancy, home visiting, CenteringPregnancy, and more.

Life course will continue to be a topic of important consideration in our section.

D. State Performance Measures

State Performance Measure 1: *Percent of women women who recently delivered a live-born infant and reported having one or more alcoholic drinks in an average week during the last 3 months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					1.5
Annual Indicator			1.7	1.2	
Numerator			189	129	
Denominator			10864	10889	
Data Source			PRAMS	PRAMS	PRAMS
Is the Data Provisional or Final?				Final	
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	1.5	1.5	1.5	1.5	1.5

Notes - 2011
Data for 2011 is not yet available.

Notes - 2010
Data for 2011 is not yet available.

a. Last Year's Accomplishments
The Alaska Birth Defects Surveillance (ABDR) program manager position that tracks reports of FAS and FASD was vacant all of FY11. Despite active recruitment, WCFH was unable to fill the position until FY12. Work on FASD data book was suspended when the program manager resigned.

FAS surveillance activities using the CDC FASSNet model remained a priority. Abstracting medical records for children reported to the registry as affected by maternal alcohol use continued.

The life course framework is used to organize work in the perinatal health program. Primary prevention and its power to improve birth outcomes and life's trajectory is the program's focus, and well suited to the issue of alcohol use during pregnancy.

Alcohol intake during pregnancy was addressed was through inclusion in both the MIECHV and Healthy Start grant planning and application process. In each case, alcohol and other behavioral health issues were a focus of the implementation plan. This included screening, brief interventions, referral, and close follow-up, as well as addressing capacity and other systems issues. Through the process of planning a home visiting program, the perinatal nurse consultant began developing a closer relationship with Alaska Division of Behavioral Health.

In September 2010 the Section of WCFH and Alaska Native Tribal Health Consortium held the Alaska MCH and Immunization Conference. This three-day conference was attended by over 200 health care providers and included sessions on alcohol intake during pregnancy and FAS/FASD.

The supply of Healthy Mother, Healthy Baby Diaries, which contain information about alcohol in

pregnancy, ran out but still time was not available to do the extensive work required prior to reprinting. Instead, the revision and reprinting was postponed, and the MIECHV grant became a priority.

PRAMS has only two years of data to report on this performance measure since it is new. In 2009 1.7% of women who had recently given birth reported having one or more alcoholic drinks in an average week during the last 3 months or pregnancy. In 2010 the number was 1.2%.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Plan Alaska MCH and Immunization conference in September 2012 to include FASD and its prevention				X
2. Continue to distribute relevant information to providers and consumers			X	X
3. Select MIECHV and Healthy Start grantees and begin to implement comprehensive perinatal programs that include alcohol prevention		X		X
4. Clean ABDR data				X
5. Make progress on MCH data book on FASD				X
6. Begin relationship with Arctic FASD Regional Training Center				X
7.				
8.				
9.				
10.				

b. Current Activities

In September 2011 the ABDS program manager position was filled. She cleaned FASD data to make it accurate for dissemination, having trend data from 1996-2011. She resumed work on the FASD data book, due to be completed early in FY13. Medical records continued to be abstracted to differentiate FAS and FASD.

Administrative approval to proceed with MIECHV implementation was granted and WFCH was awarded a Healthy Start grant, giving WCFH the opportunity to provide funding to two community organization to implement perinatal programs that address the use of alcohol during pregnancy. This funding has enabled the hiring of another perinatal nurse consultant that will increase WCFH's capacity around alcohol use during pregnancy.

Staff attended the Alaska Native Leaders Conference on FASD. There she connected with the Arctic FASD Regional Training Center, joined a workgroup, and learned more about available resources.
WCFH has been involved in planning the Alaska MCH and Immunization Conference in September. Several sessions address alcohol use in pregnancy or FASD.

Staff continues to post information to the perinatal listserv and distribute hard copies of MCH data books. The perinatal nurse consultant decided against a revision of the Healthy Mother, Healthy Baby Diary, that includes FASD prevention information, in favor or ordering a comprehensive pregnancy and newborn book for new parents entitled, "Baby and Me." It contains advice against using alcohol during pregnancy.

c. Plan for the Coming Year

The ABDR program manager will continue work on the FASD data book. Also, she plans to contact stakeholders, such as the FASD diagnostic teams to share FASD data to inform strategies, programs, and advocacy efforts.

Information and materials will continue to be distributed, such as the data books, "Baby and Me" book, and information via the listserv. The perinatal nurse consultants will get services rolling in their respective grant programs, MIECHV and Healthy Start. Home visitors and case managers will be trained with respect to alcohol use during pregnancy. This issue will be addressed in home visits and group education sessions with clients.

Other possibilities include: exploring opportunities to outreach health care providers during Birth Defects Prevention Month in January and/or FAS Awareness Day in September; partnering with the Alaska Division of Behavioral Health to distribute materials, and; supporting early prenatal care referral at facilities that provide pregnancy testing and at pregnancy test point of purchase, including advice to avoid alcohol, tobacco, and other substances.

Staff will meet to consider revising this performance measure. As a newly selected state performance measure, the measurement of one drink or more per week may prove to be too few drinks to be helpful in guiding plans and activities for women and babies at highest risk of alcohol-related problems.

State Performance Measure 2: *Rate of reports of maltreatment per thousand children 0 - 14 years of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					65
Annual Indicator				66.6	66.6
Numerator				10901	10901
Denominator				163575	163575
Data Source				Alaska Surveillance of Child Abuse and Neglect.	Alaska Surveillance of Child Abuse and Neglect.
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	65	64	64	64	64

Notes - 2011
Due to delays in obtaining data from the Office of Children's Services, the indicator reported for the 2010 Block Grant is the latest available data.

This number includes any “valid” report – validity as determined by the agency and or meets the SCAN criteria of having a valid name and date of birth. Duplicates were excluded. The indicator represents the number of children ages 0-14 with at least one valid report of maltreatment (physical, mental, sexual, or neglect). Accuracy of the indicator will be improved when more AK State Trooper and Child Advocacy Center data is included.

Notes - 2010

This number includes any “valid” report – validity as determined by the agency and or meets the SCAN criteria of having a valid name and date of birth. Duplicates were excluded. The indicator represents the number of children ages 0-14 with at least one valid report of maltreatment (physical, mental, sexual, or neglect). Accuracy of the indicator will be improved when more AK State Trooper and Child Advocacy Center data is included.

Notes - 2009
Data is only available from 2010 on.

a. Last Year's Accomplishments
The MCH-Epidemiology Unit continued to strengthen the Surveillance for Child Abuse and Neglect (SCAN) data system through: the publishing of two journal articles and one Epi-bulletin on the prevalence of maltreatment by age, community, race, and analysis of risk factors; using surveillance data to support grant applications for the MCHB/ACF Home Visitation services program; a presentation at the 2010 Child Maltreatment Conference; active participation on the Alaska Children's Justice Act Task Force (CJATF); assisting in the development of outcome indicators for the Early Childhood Comprehensive Systems (ECCS) program in the Office of Children's Services (OCS) and for programs within the Division of Behavioral Health (DBH); and mentorship of a MPH graduate student in evaluating the child advocacy center model for her master's thesis.

Prevention-related activities of the CJATF included publication and distribution of the "Guidelines for the Multidisciplinary Response to Child Abuse in Alaska"; support of the 2010 bi-annual Child Maltreatment Conference; ongoing distribution of the Mandatory Reporter training CD ; partnership with the Governor's Alaska Domestic Violence/Sexual Assault initiative to ensure measures that reduce violence against children.

The ECCS continued to promote systems integration around early childhood services. The four focus areas of ECCS were: medical homes; social, emotional, and mental health; early care and learning; and family support/parent education.
SOA public health nurses provided such population-based services as conducting routine universal screening for domestic/intimate partner violence with their clients and promoting education around zero tolerance for family violence.
DHSS's Families First! provided direct care services to families in the TANF program. Although this state initiative is not directly focused on preventing child maltreatment, it does address family risk factors that lead to maltreatment and protective factors that lead to family self sufficiency.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Alaska CJATF activities: Mandatory Reporter training CD, child maltreatment conference, and developing partnerships				X
2. Continue work on the SCAN data system: Developing partnerships and data sharing agreements, participation on the CJATF, publications, linking data sets and data analysis, and developing indicators				X
3. Operate the Family Preservation and Family Support programs through the OCS and provide training for grantees				X
4. SOA Public Health Nurses to continue conducting screening for domestic/intimate partner violence with their clients	X	X	X	
5. Administer the Maternal, Infant, and Early Childhood Home Visitation (MIECHV) program using the Nurse-Family Partnership (NFP) model		X		X

6. Administer the Healthy Start program which focuses on case-management of high-risk pregnant women and their infants, interconceptional women, and community building		X		X
7. Conduct the Alaska Safe Sleep Initiative social marketing campaign			X	X
8. Conduct and coordinate the Alaska Maternal and Infant Mortality Review Committee				X
9.				
10.				

b. Current Activities

The program manager position for the SCAN program has been vacant since August 2011. Recruitment has begun, and we hope to fill the position by August 2012. WCFH implemented a data sharing agreement with the former program manager, who is pursuing a doctoral degree in Injury Prevention at the University of North Carolina-Chapel Hill, to continue analysis of Alaska data.

Collaborations with other organizations remain an important activity. WCFH maintains membership on the CJATF. Collaboration with CJATF has been useful in identifying future areas of research and data analysis.

Other ways to address child maltreatment prevention include increased collaboration with the OCS and Southcentral Foundation home visitation programs and looking at the potential role of school nurses in education.

WCFH continues work to implement the Nurse-Family Partnership (NFP) home visitation program in Anchorage, an evidence-based program to prevent child maltreatment. It is anticipated that services will be begin in December 2012.

Alaska also continues work towards implementing the Healthy Start program. The Norton Sound Health Corporation is the selected grantee, and it is expected they will begin serving clients later in 2012. Although the mission of the program is to improve perinatal health, there are opportunities to address parent and community education around prevention of child maltreatment.

c. Plan for the Coming Year

WCFH will sponsor a symposium on violence against children and other vulnerable people in early July 2012. Four nationally recognized experts will speak on topics like integrating prevention into public practice, the importance of the child death review process, the challenges of adequately counting cases of child maltreatment at the population level, the public health model, and using data in prevention efforts. The symposium has attracted a very high level of interest. Attendees will include representatives from child advocacy centers, health care providers, the University of Alaska, the Municipality of Anchorage, the Anchorage Police Department, Alaska State Troopers, the Alaska Native Tribal Health Consortium (ANTHC), the US Department of Justice, and state agencies like OCS, the Section of Chronic Disease and Health Promotion, and the Department of Law.

A major priority for the SCAN program will be implementing data sharing agreements with the Alaska State Troopers and at least one additional Child Advocacy Center. This will improve data reporting by the surveillance system. Another priority is to continue analyzing Alaska data.

The MIECHV NFP and Healthy Start programs will be serving clients by the end of 2012. The NFP program model seeks to improve parenting skills and knowledge related to child growth and development as a part of preventing child maltreatment. As a part of the nurse home visitor

training for the MIECHV program, WCFH will collaborate with the implementing agency to provide mandatory reporter training on Alaska state statutes. WCFH will conduct continuous quality improvement evaluation of the MIECHV home visitation program and measure outcome and process indicators as listed in the benchmark plan related to reports and substantiated cases of child maltreatment.

The State Systems Development Initiative (SSDI) federal grant program will be used to stretch MCH funding by partially supporting a research analyst position within MCH-Epidemiology. This will increase WCFH capacity for linking data sets to analyze longitudinal data around health outcomes and domestic violence and support the SCAN program.

WCFH will continue to investigate ways to realign program activities to focus on infrastructure building and population-based services addressing child maltreatment as well as raising awareness among community partners on the public health aspect of preventing child maltreatment.

State Performance Measure 3: *Percent of mothers who report tooth decay in their 3-year old child.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					10
Annual Indicator		13.4	14.8	17.0	
Numerator		1305	1521	1739	
Denominator		9713	10282	10234	
Data Source		Alaska Childhood Understanding Behaviors Survey	Alaska Childhood Understanding Behaviors Survey	Alaska Childhood Understanding Behaviors Survey	Alaska Childhood Understanding Behaviors Survey
Is the Data Provisional or Final?				Final	
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	10	10	10	10	10

Notes - 2011
Latest data is for 2010.

Notes - 2010
Latest data is for 2010.

a. Last Year's Accomplishments
The indicator is from the Childhood Understanding Behaviors Survey (CUBS) on mothers reporting a health care provider has indicated their child has tooth decay or cavities (for 3-year

old children). CUBS data from 2010 indicated 17.0% of mothers reported they had been told by a health care provider that their 3-year old had dental decay -- as compared with 14.8% in 2009 and 13.4% for this indicator in 2008. This indicator would typically under-report dental decay (caries) prevalence as many children under age 3 have not received a dental visit, the information would not include caries developed since a previous dental screening or exam and/or the mother may not remember what the child's health care provider indicated with respect to dental decay. Dental assessments utilizing the Basic Screening Survey (BSS) protocol for Alaskan kindergarten children, an older age group than for this indicator, found 48% had caries experience (treated or untreated dental decay) in 2005; 41% had caries experience in the 2007 BSS; and 41% with the 2010/2011 BSS.

Caries is the most common chronic disease among U.S. children -- 5 times more common than asthma and 7 times more common than hay fever. Caries also is a frequent unmet health need especially in young children as first dental visits often occur in the 3-5 years age range. Early childhood caries (ECC) is a rapidly progressing form of the disease associated with active caries in the caregiver and transmission of bacteria associated with caries and feeding practices. ECC is not only costly to treat since children require undergoing dental treatment in an operating room under general anesthesia, but can affect speech development and learning, nutrition, behavior management issues and the child's quality of life. Due to these concerns, it is typically recommended that a child receive a dental exam with the eruption of the first tooth and no later than age one in order for early detection of ECC risk and provision of information to parents on nutrition, feeding practices, and oral hygiene.

In July 2010 Medicaid began reimbursement coverage for oral evaluation (caries risk assessment) for children under the age of three and fluoride varnish application for all children conducted by trained physicians, nurse practitioners and physician assistants. The OHP offered a training workshop on these dental procedures in April 2011 for these medical provider types and links to other information for training (e.g., smilesforlifeoralhealth.org) have been noticed by Medicaid. Children enrolled in Medicaid are typically at higher risk for caries and ECC development due to factors related with lower income-status of the families.

The OHP has continued working with Head Start and SOA Public Health Nursing (PHN) to develop key messages for health programs to provide to parents and caregivers on water fluoridation, use of topical fluorides, and reducing risk for dental decay in young children. This information is available to programs interested in developing or purchasing educational brochures on these topics.

The OHP also supports community water fluoridation in communities choosing to implement this evidence-based approach for reducing caries. Unfortunately, recent experiences in Alaska illustrate losing community support for water fluoridation with concerns expressed by fluoridation opponents despite the ongoing work done by the U.S. Department of Health and Human Services (DHHS), including the Centers for Disease Control and Prevention (CDC), illustrating the effectiveness and safety of this population-based approach. This past year water fluoridation was discontinued in Fairbanks (after a previous effort resulted in a city council vote to continue fluoridation in 2008).

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support community water fluoridation			X	X
2. Collect maternal reporting of dental decay on their 3 year old children				X
3. Conduct dental assessments utilizing the ASTDD “Basic Screening Survey” protocol (kindergarten & third grade)			X	X

4. Provide information on appropriate fluoride use (water fluoridation and topical fluorides)			X	X
5. Support Medicaid reimbursement for oral evaluation (< 3 year old children) and fluoride varnish application for medical providers		X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The OHP supports community water fluoridation and provided information/testimony for the City of Bethel in their local vote (voted to continue fluoridation). The OHP will provide information when DHHS adopts new guidelines on fluoride concentration levels (proposed 0.7 mg/L vs. current 0.7--1.2 mg/L).

The OHP is convening an advisory group to develop a dental periodicity schedule for Medicaid (EPSDT program) to promote earlier dental visits. The OHP presents/discusses the need with pediatric dentists/Tribal dental programs to reduce the prevalence/severity of ECC in Alaska.

The OHP applied for a HRSA grant to expand school-based sealant programs and conduct training for ECC prevention. Award notice is in August 2012.

The OHP collaborates with the Alaska Dental Action Coalition (ADAC) to revise the oral disease burden document and state oral health plan by July 2012. ADAC and key stakeholders participated in the Children's Dental Health Project "Policy Tool" process in September 2011 to identify top priorities for the next 3 years. ADAC and the OHP also identified recommendations, activities and policies to address oral health/dental access in the next 5 years. This information is used to update the state plan. Priorities include strategies to reduce child intake of soda/sugar-sweetened beverages and strategies to increase dental access/improve the oral health of CYSHCN.

Current surveillance data, including 2010/11 BSS data, will be used to update the state plan.

c. Plan for the Coming Year
The program will continue to educate on the role of water fluoridation, fluorides and dental sealants in reducing dental decay -- including information on the USDHHS final adoption of fluoride concentration for water fluoridation when it occurs. The OHP will continue to seek opportunities to encourage medical provider involvement with caries risk assessment and early childhood caries prevention along with encouraging dental visits by age one (especially for children at high risk for caries). If the OHP receives HRSA grant funding, staff will be working collaboratively with FQHC dental programs to expand school sealant pilot programs and organize health professional workshops to improve training for treating special needs populations and collaboration with medical providers to address caries risk assessment and early childhood caries prevention.

The program is hoping for Medicaid adoption of the separate dental periodicity schedule for Early & Periodic Screening, Diagnosis and Treatment (EPSDT) Program -- along with information to encourage early dental visits.

OHP funding provided by the U.S. Centers for Disease Control & Prevention (CDC) will end July 2013 -- the OHP will be preparing a new competitive CDC funding application in the spring of 2013. CDC funding is the primary funding source for the OHP staffing.

State Performance Measure 4: *Percent of women who recently delivered a live-born infant and are not doing anything now to keep from getting pregnant.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					16
Annual Indicator			16.5	20.2	
Numerator			1789	2180	
Denominator			10854	10811	
Data Source			PRAMS	PRAMS	
Is the Data Provisional or Final?				Final	
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	15	15	15	15	15

Notes - 2011
Data for 2011 is not yet available.

Notes - 2010
Data for 2011 is not yet available.

a. Last Year's Accomplishments
Prenatal and postpartum education materials emphasized the benefits of breastfeeding for both baby and mother. Messages include the fact that breastfeeding delays ovulation but that additional protection from unplanned pregnancy may be needed. The Reproductive Health Partnership (RHP) and Adolescent Health Program staff collaborated with Alaska Native mothers, the WIC nutrition program, and tribal health perinatal nurses to produce a birth spacing brochure describing the benefits of breastfeeding, risk for subsequent pregnancy during the postpartum period, and a guide for developing a personal contraceptive care plan for the woman to share with her care provider. The Women's Health Unit (WHU) disseminated this birth spacing media campaign featuring Alaskan families and carrying messages about the risk of unplanned pregnancy during the post-partum period.

WHU staff were aware that many mothers never received a postpartum check up and that those covered by state Medicaid had lost that coverage option, and with it the opportunity for contraceptive care, at six weeks postpartum. These factors were believed to have influenced lack of adequate contraceptive coverage for many. WHU promoted CDC's US Medical Eligibility for Contraceptive Use 2010 in all trainings and on the Alaska Women's Health Program clinical network listserv and website. Few Alaskan health care providers have skill or experience with insertion of the intrauterine contraceptive device at ten minutes after delivery of the placenta.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Disseminate educational materials to care providers (contraception, breastfeeding, condoms, risk of pregnancy during postpartum period)				X
2. Train clinical care providers on counseling about contraception, breastfeeding, condoms, risk of pregnancy during postpartum period				X
3. Promote and disseminate birth spacing media campaign			X	

materials				
4. Promote use of CDC's US Medical Eligibility for Contraceptive Use, 2010 & Update on Use of Contraceptives During Postpartum Period				X
5. Skills building trainings for Public Assistance staff to promote birth spacing among their clients				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Issues and activities for FY11 related to breastfeeding and contraceptive care continue. WHU and RHP continue to promote and disseminate the birth spacing tool.

RHP promotes CDC's US Medical Eligibility for Contraceptive Use 2010 in all trainings, on the women's health provider listserv and Alaska Women's Health Program website. Few Alaskan health care providers have intrauterine contraceptive device skill or experience with insertion ten minutes after delivery of the placenta.

c. Plan for the Coming Year
FY12 activities related to breastfeeding and contraceptive care will continue. WHU staff will continue to disseminate their birth spacing media campaign materials with messages covering the benefits of breastfeeding, risk for subsequent pregnancy during the postpartum period and potential need for contraceptive care. WHU staff will conduct an evaluation of the birth spacing media campaign and report those results to all stakeholders.

AWHP will continue to promote CDC's US Medical Eligibility for Contraceptive Use 2010 and the Update: Revised Recommendations for the Use of Contraceptive Methods During the Postpartum Period, in all trainings and on the AWHP clinical network listserv and website.

Skills building trainings will be provided for Public Assistance case managers who work intensively with pregnant and postpartum women. The focus of the trainings will be to introduce motivational interviewing and effective referral to women's health care services, including contraceptive care. The training model will continue to include a simple guide to support the woman to develop a personalized contraceptive care plan with her care provider.

WHU staff will collaborate with clinical providers to facilitate effective referrals of women in need of contraceptive care for birth spacing.

State Performance Measure 5: *Percent of high school students who were hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the previous 12 months.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance					8

Objective					
Annual Indicator		12.4	13.3	13.3	12
Numerator					
Denominator					
Data Source		AK Youth Risk Behavior Surveillance System	AK Youth Risk Behavior Surveillance System	AK Youth Risk Behavior Surveillance System	AK Youth Risk Behavior Surveillance System
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	8	8	8	8	8

Notes - 2011
Numerators and denominators for the YRBSS are not reported.

Notes - 2010
Numerators and denominators for the YRBSS is not reported. The latest available data is for 2009.

Notes - 2009
The latest available data is for 2009.

a. Last Year's Accomplishments
The Adolescent Health Program (AHP) served as an active member of a domestic violence and sexual assault prevention steering committee, providing guidance on the prevention of dating violence. The AHP established a wide network of collaborating agencies with which it is consistently collaborated and planned future work.
The AHP helped plan and sponsor a statewide youth leadership event entitled, Lead On! The event focused on teaching youth methods for community engagement to prevent dating violence.

The AHP collaborated with non-profit and State agencies to continue funding the multi-media Stand Up, Speak Up campaign aimed at reducing unhealthy relationships in teens and increasing youth leadership throughout the state.

The AHP continued endorsing The Fourth R, a Canadian curriculum which focuses on establishing healthy relationships as a way to reduce substance abuse, violence and teen pregnancy. Several teacher trainings were held, where teachers were trained in the implementation of the Fourth R curriculum. The AHP is managing a federal PREP grant using The Fourth R curriculum: teachers throughout Alaska are using it to teach in schools.

The AHP continued to work with the Youth Alliance for a Healthier Alaska, an advisory committee comprised of all youth that advises the State on important matters relevant to teens, including violence prevention.

The AHP funded the Alaska Network on Domestic Violence and Sexual Assault to distribute community grants to youth groups to conduct youth engagement for the prevention of dating violence activities at the community level.

The AHP continued promoting a birth spacing brochure aimed at encouraging women to wait at least two years before pregnancies and discussing healthy relationships with partners.

In 2010, 12% of students were hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the 12 months before the survey.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement Stand Up, Speak Up campaign				X
2. Youth Alliance Conduct for a Healthier Alaska youth group	X			X
3. Promote The Fourth R curriculum in Alaska schools and manage PREP grant			X	
4. Evaluate The Fourth R in Alaska schools				X
5. Distribute birth spacing materials through social marketing campaign			X	X
6. Evaluated birth spacing campaign				X
7. Give presentations on dating violence prevention		X		
8. Administer grant to ANDVSA for youth engagement to prevent violence	X		X	X
9.				
10.				

b. Current Activities
All AHP projects started in FY 11 continued into FY 12.

We have started collaborating with partners to conduct an evaluation of The Fourth R curriculum.

During the summer of 2011, an MCHB intern conducted a process and outcome evaluation of the birth spacing campaign. Results were used to improve delivery methods.

We will hire a new Health Program Associate to help conduct the fidelity monitoring evaluation component of The Fourth R.

c. Plan for the Coming Year
All ongoing projects from FY 12 will continue through FY 13.

Principals, teachers, teacher's aides, substitute workers, school nurses, and other interested school staff from alternative schools in Anchorage and the Mat-Su Valley will be offered training on healthy adolescent relationships and communicating effectively with teens. These staff members are all mandatory reporters of sexual abuse of minors who spend at least six hours each day working with and around at-risk teens. Increasing the knowledge for adults who have so much contact with at-risk youth is a critical need.

The AHP has requested a Public Health Prevention Specialist Fellow for FY 13 and FY 14 to engage youth in violence prevention through leadership activities.

State Performance Measure 6: *Percent of women who recently had a live-born infant and experienced intimate partner violence during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011

Annual Performance Objective					4.1
Annual Indicator			4.6	4.8	
Numerator			494	515	
Denominator			10749	10729	
Data Source			PRAMS	PRAMS	PRAMS
Is the Data Provisional or Final?				Final	
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	4.1	4.1	4.1	4.1	4.1

Notes - 2011
Data for 2011 is not yet available.

Notes - 2010
Data for 2011 is not yet available.

a. Last Year's Accomplishments
The Alaska Family Violence Prevention Project (AFVPP) provides technical assistance, outreach, and public education as part of its mission to improve the health of Alaska's women, adolescents, infants, children, and families. In addition, the AFVPP is dedicated to improving the health of all mothers, adolescents, and children through its leadership for research and development of training resources, policy development, and national standards for addressing intimate partner violence including dating violence and reproductive coercion within the context of health care and public health. Working closely with community partners, the AFVPP represents service in three areas: enabling (for outreach and health education), population-based (for injury prevention), and infrastructure-building (for policy development, planning, coordination, standards development, training, and information systems).

AFVPP started research on the development of an integrated screening tool for intimate partner violence (IPV), depression and substance abuse that can be used in perinatal settings. The AFVPP conducted an on-line survey with public health nurses on addressing IPV and started a seven-part, statewide webinar training series for public health nurses addressing the effects of IPV on women's reproductive health and assessment for sexual and reproductive coercion. The AFVPP expanded its curriculum on adolescent brain development to include content on dating violence, unintended pregnancies, sexual coercion, and promoting healthy relationships and provided several trainings including the Alaska Society for Technology in Education conference, an Alaska School District Education Center training event, the Seldovia Health Fair, a community forum in Homer, and teachers in-services and parents' night in Petersburg.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue operating the clearinghouse to disseminate resources on intimate partner violence and reproductive coercion throughout Alaska		X	X	X
2. Develop a safety card on intimate partner violence and reproductive and sexual coercion for Alaska Native Health corporations			X	X
3. Plan and conduct a second train-the-trainers on adolescent brain development, dating violence and substance abuse for multidisciplinary teams of service providers				X
4. Provide technical support and resources to our training teams				X
5. Provide additional training on dating violence and reproductive and sexual coercion for the Kenaitze tribe				X

6. Pilot the safety card in two regional villages to ensure cultural relevance			X	X
7. Conduct two regional trainings for Alaska Native Health Corporations on assessment for intimate partner violence and reproductive and sexual coercion				X
8. Conduct workshop on screening for intimate partner violence and reproductive coercion at statewide MCH and immunization conference				X
9. Conduct all day workshop with content on dating violence and reproductive coercion at statewide psychologist conference				X
10. Presentation on healthy relationships and dating violence at women's and girls' community wellness event				X

b. Current Activities

The AFVPP completed the webinar training series on IPV and reproductive coercion with public health nursing and provided technical assistance on validated screening tools. The AFVPP worked with a community team to develop the integrated assessment tool for IPV. Interviews were conducted with patients and clinical providers at several different clinics and the tool was adapted to be more culturally relevant. The AFVPP provided a half-day workshop on IPV and reproductive coercion at a statewide reproductive health care provider conference in May, 2011. The AFVPP provided training on dating violence, unintended pregnancies and reproductive coercion at events around the state including a Title VII Indian Education conference, the school nurses' conference in Fairbanks, the Cordova School District teacher in-services, the Kenaitze tribe and a tribal conference. The AFVPP expanded its curriculum on adolescent brain development to include more content on dating violence, reproductive and sexual coercion, and healthy relationships. AFVPP launched the curriculum in March, 2012 with teams of service providers from 14 different regions who participated in train-the-trainers on adolescent brain development, dating violence, and substance abuse. The AFVPP continues to provide technical support and training resources on dating violence prevention to the teams.

c. Plan for the Coming Year

The AFVPP will continue to participate in the Governor's work group and committees on domestic violence and sexual assault with particular emphasis on best practices. The AFVPP will continue to provide training that addresses dating violence and reproductive coercion throughout the state. The AFVPP will conduct another train-the-trainer for multidisciplinary teams of service providers from around the state in 2013 and provide ongoing technical assistance and resources to our training teams. We will continue to operate our clearinghouse and acquire up-to-date resources to share with communities.

State Performance Measure 7: *Percent of women who delivered a live birth and had a provider talk to them about post partum depression since their new baby was born.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					88
Annual Indicator			80.4	81.1	
Numerator			8412	8522	
Denominator			10467	10513	
Data Source			PRAMS	PRAMS	PRAMS
Is the Data Provisional or Final?				Final	
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	88	88	88	88	88

Notes - 2011
Data for 2011 is not yet available.

Notes - 2010
Data for 2011 is not yet available.

a. Last Year's Accomplishments
The postpartum counselor continued to manage the perinatal depression program and provide outpatient counseling and facilitate a support group for women with perinatal depression. Also, she developed Providence-branded materials to use. The WCFH perinatal nurse consultant continued to support the project by facilitating professional continuing education opportunities and distributing materials.

The major focus was completion of the grant processes for two programs designed, among other things, to address behavioral health issues like perinatal depression. The Healthy Start and MIECHV grant application, including a needs assessment and updated state plan were submitted and approved by federal officials.

In September 2010 the Alaska MCH and Immunization Conference was held. The postpartum counselor presented on maternal depression and its effects on the family.

Data shows percent of women who delivered a live-born infant who were talked to by a doctor, nurse, or other health care worker about postpartum depression has been relatively constant since 2005. PRAMs data for 2010 reveals 81.1% of women who delivered a live-born infant were talked to by a doctor, nurse, or other health care worker about postpartum depression. This is an increase of 0.7% from 2009 to 2010.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribute educational materials			X	X
2. Coordinate workshop on mental illness screening during pregnancy for 2012 Alaska MCH and Immunization Conference			X	X
3. Update materials on postpartum depression for Alaska WCFH perinatal health website			X	X
4. Incorporate screening for postpartum depression into MIECHV and Healthy Start programs				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
WCFH is focusing its efforts related to perinatal depression on the two large 5-year grants it was recently awarded. The Healthy Start grant was awarded this year, and the Norton Sound Health Corporation was selected to implement the project in Nome. This program will be critical in providing screening and referrals for women who report symptoms of maternal depression. It is anticipated that they will begin serving clients in September.

An additional perinatal nurse consultant was hired in March of 2012 to manage the new Maternal

Infant Early Childhood Home Visitation (MIECHV) grant, which includes a component on perinatal depression screening and referral. WCFH is currently negotiating a contract with an agency to provide this service in Anchorage.

A perinatal nurse consultant participated on the planning committee for the 2012 Alaska MCH and Immunization Conference to be held in Anchorage in September. This conference will include a speaker on screening for mental health issues during pregnancy.

The perinatal nurse consultants are in the process of reviewing and updating the content of the perinatal health program website which includes electronic and printed resources on postpartum depression. Information is also distributed on the perinatal list serve. "Baby and Me," a comprehensive resource book for pregnant women and new parents, was recently ordered in bulk for distribution. It contains content on perinatal depression.

c. Plan for the Coming Year

The perinatal nurse consultant will continue to distribute perinatal materials such as the "Baby and Me" book and including the HRSA booklet "Depression During and After Pregnancy" through a variety of channels. Information will continue to be included in the list serve as well as through the perinatal health webpage currently being updated and in possible development of a perinatal health Facebook page.

As both new perinatal grant programs develop and begin to serve clients, more women will be screened for symptoms of maternal depression. The MIECHV grant will implement the Nurse-Family Partnership (NFP) model that has a performance measure in the benchmark plan related to screening. Both the nurse home visitors of the MIECHV grant and paraprofessional home visitors of Healthy Start will utilize the Edinburgh Postnatal Depression Scale (EPDS) on a defined schedule. As a part of the training curriculum for the home visitors, WCFH will be requesting the assistance of the postpartum counselor at the Children's Hospital of Providence. Healthy Start also will use a benchmark related to screening for symptoms of maternal depression which will continue to be evaluated as the program progresses.

The 2012 Alaska MCH and Immunization Conference will have a workshop entitled "Screening during pregnancy: Substance and mental health issues," as well as other sessions related to substance use.

State Performance Measure 8: *Percent of women who recently had a live-born infant and reported having one or more environmental factors in the home that are associated with SIDS/unexplained asphyxia.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					60
Annual Indicator			68.8	68.3	
Numerator			7245	7307	
Denominator			10537	10701	
Data Source			PRAMS	PRAMS	PRAMS
Is the Data Provisional or Final?				Final	
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	60	60	60	60	60

Notes - 2011

Data for 2011 is not yet available.

Notes - 2010
Data for 2011 is not yet available.

Notes - 2009
Although the percentage is high, few mothers (27%) are placing baby on the side or stomach. 31% have crib bumper pads, 32% have blankets, 17% have pillows, and 5% have toys in the crib. Understanding the specific breakdown of crib items will help us craft social messaging.

a. Last Year's Accomplishments
The life course framework is used to organize work in the perinatal health program. Primary prevention and its power to improve birth outcomes and life's trajectory is the program's focus, and is nowhere more obvious than in its power to prevent the unnecessary death of an infant.

Materials continued to be distributed. A new listserv format was implemented to increase the reach of the perinatal information, including that related to infant safe sleep. The MIMR process continued. An annual report was produced on MIMR findings.

The consultant piggybacked on abusive head trauma training to share information on the Alaska Infant Safe Sleep Initiative and recruit task force members. The task force continued to meet, as did a small group of staff including a DPH deputy chief and the chief medical examiner, to discuss to the infant safe sleep position statement.

This year The Watson Group social marketing firm completed a comprehensive analysis of the focus group data and made recommendations for social marketing messages and strategies. The Section of WCFH was awarded a CJ Foundation for SIDS grant for $10,000. This, combined with block grant funds, enabled WCFH to award two more contracts for social marketing work.

The Alaska Infant Safe Sleep Summit was held in September 2010 in conjunction with the Alaska MCH and Immunization Conference. The summit was attended by 110 individuals. The keynote speaker addressed cultural competence in SIDS/SUID work. Response to the summit was enthusiastic. WCFH staff and ANTHC were busy during much of FY11 in planning for the 2012 conference.

The perinatal nurse consultant presented at the November 2010 International Conference on Pregnancy Loss and Infant Death on cultural considerations of infant sleep-related death.

Data from the new PRAMS question on safety of the infant sleep environment, revealed 68.3% of new moms reported risk factors associated with infant sleep-related death, similar to last year. Sleeping on side or stomach comprised 32%, with a blanket 32%, use of bumper pads in crib 28%, pillows 16%, and toys about 6%.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribute materials to health care providers				X
2. Reconvene task force to provide guidance to project				X
3. Work with All-Alaska Pediatric Partnership to support hospitals to educate staff and patients about infant safe sleep				X
4. Work with Public Information Team to design and produce Alaska infant safe sleep pamphlet and poster				X
5. Plan for presence at the Alaska MCH and Immunization Conference in September				X

6. Continue conducting the MIMR process				X
7. Present infant safe sleep content to a variety of audiences				X
8. Recognize Infant Mortality Awareness Month in September with roll-out of materials and updated web content				X
9.				
10.				

b. Current Activities
Materials and other information continue to be distributed. The new listserv has grown from about 130 subscribers to almost 500. Staff presented at grand rounds, conferences, and other events. An infant safe sleep position statement was approved and distributed to DHSS. The section published an MMWR on postneonatal mortality with national distribution. The MIMR committee continues to review infant deaths.

Findings and analysis of The Watson Group, the contracted social marketing firm, are being used to guide development of a brochure and poster due to be debuted in September for Infant Mortality Awareness Month and during a presentation at the MCH conference. WCFH staff has met to begin work on these materials.

Infant safe sleep task force members were asked to review the materials and help develop a distribution plan. Also, the task force is starting a plan to help Alaskan hospitals educate both staff and patients about infant safe sleep. The All-Alaska Pediatric Partnership is collaborating in this effort.

"Baby and Me," a comprehensive prenatal and newborn book for parents has been ordered in bulk and will be distributed to pregnant women. It contains a section on infant safe sleep.

c. Plan for the Coming Year
The current methods of disseminating information about infant safe sleep will continue. In addition, in the coming year WCFH will present on infant safe sleep at the Alaska MCH and Immunization Conference and begin a statewide distribution of the soon to-be-produced pamphlet and poster that will be designed using input from focus groups and recommendations from The Watson Group.

WCFH is in the process of updating the perinatal page of the website and this will include a page to recognize Infant Mortality Awareness Month in September. The hope is that web content from the brochure and poster will be ready to post to the website by September 1st.

Two federal grant programs, MIECHV and Healthy Start, will begin serving clients this fiscal year and will incorporate infant safe sleep strategies in home visits and other health education venues.

The Alaska Infant Safe Sleep Task Force will continue to meet quarterly. Besides wrapping up review and publication of the brochure and poster, and assisting with a statewide distribution of materials, the task force will focus on supporting Alaskan hospitals in their efforts to teach staff and patients about risk and protective factors for infant sleep-related death.

State Performance Measure 9: *Percent of mothers who report their 3-year-old child had a BMI greater than the 85th percentile (overweight and obese).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					25
Annual Indicator		41.2	40.6	39.5	
Numerator		3480	3587	3338	
Denominator		8439	8833	8456	
Data Source		Alaska Childhood Understanding Behaviors Survey	Alaska Childhood Understanding Behaviors Survey	Alaska Childhood Understanding Behaviors Survey	Alaska Childhood Understanding Behaviors Survey
Is the Data Provisional or Final?				Final	
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	25	25	25	25	25

Notes - 2011
Latest data is for 2010.

Notes - 2010
Latest data is for 2010.

a. Last Year's Accomplishments
The Obesity Prevention and Control Program (OPCP) helped develop Measuring Height & Weight and Calculating BMI Guidelines for Schools, along with the State's School Health Nurse Consultant and the School Health Nurse Advisory Committee (SHNAC). The OPCP assisted a MPH graduate student in the design of a thesis that researched health care provider knowledge and practices related to childhood obesity and overweight.

The OPCP staff participated in the development of a state breastfeeding plan.

The OPCP presented evidenced-based obesity prevention and control strategies to professional organizations including the Alaska Health Care Commission, the public health nurses conference, Alaska MCH and Immunization Conference, and the community health aides instructor convocation.

The OPCP monitored the prevalence of obesity and related risk factors and disseminated related reports including evidenced-based prevention recommendations.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Developed and implemented a school-based physical activity challenge and marketing campaign			X	
2. Provided evidence-based physical education curriculum				X

training for PE teachers				
3. Present evidenced-based obesity prevention and control strategies to professional organizations				X
4. Facilitate the Alaska Food Policy Council				X
5. Pilot tested a SNAP EBT program at two farmers' markets			X	
6. Monitor the prevalence of obesity and related risk factors and disseminate related reports including evidenced-based prevention recommendations and work to expand monitoring systems to improve the quality of our information				X
7.				
8.				
9.				
10.				

b. Current Activities

The OPCP developed and is now implementing a school-based physical activity challenge and marketing campaign to encourage youth and families to be more active. The OPCP provided evidence-based physical education curriculum training for PE teachers throughout the current fiscal year.

OPCP staff facilitate the Alaska Food Policy Council to strengthen policies and local food systems to ensure access to affordable, nutritious, culturally appropriate food for all Alaskans. During this fiscal year, the OPCP conducted a pilot project to determine utilization of Electronic Benefit Transfer (EBT) of Supplemental Nutrition Assistant Program (SNAP) recipients at farmers' markets.

The OPCP presents evidenced-based obesity prevention and control strategies to professional organizations including the Alaska Head Start Association; the public health nurses conference, Alaska MCH and Immunization Conference, and the Alaska Parent, Teacher and Student Association.

The OPCP continues to monitor the prevalence of obesity and related risk factors and disseminate related reports including evidenced-based prevention recommendations. The program also works to expand monitoring systems to improve the quality of information produced.

c. Plan for the Coming Year

The OPCP will continue to work on policy, system, and environmental change to improve access and affordability of healthy foods and access to physical activity for all Alaskans. The OPCP will run the school-based physical activity challenge and marketing campaign again to encourage youth and families to be more active. Staff will facilitate the Alaska Food Policy Council to strengthen policies and local food systems to ensure access to affordable, nutritious, culturally appropriate food for all Alaskans. Staff will expand the Alaska Farmers' Market-Quest Program to improve access to healthy foods for low income Alaskans. They will also assist schools with implementing salad bars in schools to increase access to fruits and vegetables for youth.

The OPCP will continue to monitor the prevalence of obesity and related risk factors and disseminate related reports including evidenced-based prevention recommendations.

The Section of Women's, Children's and Family Health (WCFH) will lead a section workgroup on efforts to prevent and reduce the burden of obesity throughout the life course. They will address healthy pregnancy weight in their Healthy Start and MIECHV grants they administer, which includes a focus on breastfeeding promotion and nutrition for toddlers.

WCFH staff will be active in the Alaska Breastfeeding Coalition and will collaborate with WIC to support breastfeeding and reduce obesity.

WCFH will continue efforts to establish a space for breastfeeding moms who working in the Anchorage Frontier Building.

State Performance Measure 10: *Percent of late preterm births at 34 - 36 weeks gestation.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					5
Annual Indicator		6.4	6.6	6.3	
Numerator		736	752	719	
Denominator		11438	11315	11470	
Data Source		AK Bureau of Vital Statistics.	AK Bureau of Vital Statistics.	AK Bureau of Vital Statistics.	AK Bureau of Vital Statistics.
Is the Data Provisional or Final?				Final	
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	5	5	5	5	5

Notes - 2011
The latest available data is for 2010.

Notes - 2010
The latest available data is for 2010.

a. Last Year's Accomplishments
The life course framework is used to organize work in the perinatal health program, and is especially relevant in the prevention of late preterm birth. Information about late preterm birth was shared via the new listserv. The perinatal nurse consultant maintained an active membership on the state of Alaska's March of Dimes (MOD) Program Services Committee, whose national priority is prematurity.

The MOD Alaska Chapter focused on implementation of a pilot project to test the late preterm birth toolkit that was already in use in multiple sites across the country. The perinatal nurse consultant was involved in discussions and recommendations related to selecting a site and planning for implementation. MOD approached potential hospitals about their interest in piloting the 39 Weeks Toolkit. Alaska Native Medical Center, Mat-Su Regional Medical Center and Fairbanks Memorial Hospital (Banner Health) already prohibit early elective inductions.

Data available for this performance measure, beginning in 2008, shows the late preterm birth rate in Alaska at 6.4 in 2008 and 6.6 in 2009, and 6.3 in 2010.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Continue to distribute late preterm birth information electronically				X
2. Collaborate with MOD on 39 Weeks campaign				X
3. Publish a statewide epidemiology bulletin on late preterm birth				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Information on preterm birth is distributed electronically, through conferences, and by mail. WCFH published an epidemiology bulletin which was distributed statewide and the topic was included on the MCH conference agenda. A large order of "Baby and Me," a comprehensive prenatal resource book for pregnant women and new parents, containing content on prematurity, has been made.

WCFH epidemiology and program staff has collaborated with March of Dimes on their 39 Weeks campaign to reduce late preterm birth by supporting hospitals to implement a hard stop on early elective deliveries. This work focuses on near term, from 37/0 to 39/6 weeks of gestation (requiring an update of this performance measure). In February 2012 a group began meeting that included hospital representatives of the All-Alaska Pediatric Partnership. Obstetric grand rounds on implementing a hard stop was conducted in Anchorage, the Mat-Su Valley, and Fairbanks in June 2012.

Two large perinatal grants were awarded to WCFH this year. A new perinatal nurse consultant was hired which will increase our capacity to address late preterm-birth.

We were one of two states to receive the MOD Virginia Apgar Prematurity Award for reducing preterm birth by at least 8% from 2009 to 2010. In fact, our reduction was 15.7%.

The MOD Director of Program Services left his position in June and progress on this issue will depend on his replacement.

c. Plan for the Coming Year

The 39 Weeks committee will continue to meet with a big milepost anticipated in November being a hard stop of elective early deliveries in Alaska's largest birthing hospital. Another obstetric grand rounds is being planned to occur in concert and to recognize November as Prematurity Awareness Month. Activities will likely include a social marketing campaign to educate the public of the risks associated with near term deliveries to decrease pressure on health care providers to deliver early.

WCFH will continue to distribute information to health care providers and the public. Healthy Start and MIECHV grants will allow WCFH to address the issue of client education around late preterm birth in specific populations. Training for home visitors and case managers will be include this topic.

E. Health Status Indicators

Introduction

Many of the HSI indicators are reported in the MCH Data Books published by the MCH Epidemiology Unit every two years. Every third year the Data Book features a comprehensive look at maternal and child health indicators. In interim years, Data Books focus on specific MCH topics, presenting the findings of public health surveillance programs operated by the MCH Epidemiology Unit. Previous Data Books covered data from PRAMS and data from the Alaska Birth Defects Registry. The Data Book published in October 2011 focused on health status indicators for the Alaska Native population, in collaboration with the ANTHC EpiCenter. The next data book, to be published Fall 2012, is an uupdate of the Alaska Birth Defects Registry. They are available online at http://www.epi.hss.state.ak.us/mchepi/mchdatabook/default.htm.

The MCH Epidemiology Unit also publishes the Special Series Fact Sheets are a set of 42 condensed fact sheets addressing prevalence, trends, comparisons to the national baseline, disparities, and interventions and recommendations on a variety of health topics. The fact sheets are online at http://www.epi.hss.state.ak.us/mchepi/MCHFacts/na.htm.

There are no barriers to accessing any of the HSI data. Birth certificate data is used to analyze many of the perinatal conditions.

Singleton low birthweight births (1500 - 2499 grams) has been trending downward since 2005 but is a disparity between Alaska Native and non-Native infants. During 2000 - 2004, low birthweight proportions were similar among the two groups. From 2004 to 2006 low birthweight births among Alaska Native infants were lower than for non-Native infants, but the disparity was reversed starting in 2008.

Overall preterm (prior to 37 weeks completed gestation) birth rates have fluctuated between 10.1% and 11.2% during 2000 - 2010. For this period, Alaska preterm rates averaged 15% below the national rate. In 2010, the rate dropped by 11.8% from the previous year. For this achievement, Alaska was one of two states honored by the March of Dimes for achieveing their challenge of reducing preterm births by at least 8%. In 2012 WCFH partnered with the All Alaska Pediatric Partnership (AAPP) and the March of Dimes to collect data on trends in non medically indicated early term births (37-38 completed weeks gestation). Findings were documented in an Epi Bulletin "Non-medically Indicated Early Term Deliveries in Alaska, 2005-2010" (available at http://www.epi.hss.state.ak.us/
bulletins/docs/b2012_09.pdf). The data analysis demonstrated that non-medically indicated early term births, as measured by birth certificate documentation, has been decreasing since 2005, and that there are disparities in the rates among six hospitals in the state that collectively handle 65% of births. "Hard stop" policies are being implemented or are being considered at some of the hospitals. WCFH will continue to help monitor and evaluate early term births as hospital policies regarding elective induction and c-sections are implemented in the future. The rate of non-medically indicated early term birth is also being considered as a Medicaid quality improvement measure at the national level. Limitations of using birth certificate data as a measuring tool is noted.

Over the last 30 years, Alaska cut infant mortality by 54%, and in 2010 overall infant mortality decreased by 45% from 2009, the largest single year decline since 1980! It is difficult to attribute this happy trend to any one factor. Preterm rates dropped significantly, maternal education levels were slightly elevated, and smoking was down somewhat. Teen birth is not a significant contributor to infant mortality in Alaska.

The Maternal Infant Mortality Review (MIMR) and Child Death Review (CDR) remain important as internal review processes. Lag times for reviewing infant mortality cases have been cut to about two years; the Committee is currently working on 2010 deaths. Some members of the MIMR and CDR are also members of the Children's Justice Task Force as well as on an unofficial student advisory group guiding research on child maltreatment prevention. These connections are

already proving useful in bridging the large gap between public health prevention and programs delivered at the family level. WCFH continues to work towards connecting upstream and downstream interventions within the lifecourse framework.

MIMR data was used to inform the community on environmental risk factors for sudden unexplained infant death/unexplained asphixia. WCFH and the Perinatal Advisory Committee continue to work on public health messages for the infant safe sleep initiative.

F. Other Program Activities

The Toll free hotline is combined with the main number for the Title V/CSHCN program. Approximately 20 calls per day come into this number with most callers requesting to talk with one of the staff members. A total of 400 calls were received for state fiscal year 2010 requesting information on specific programs or looking for information regarding services such as WIC, Medicaid, services for children with autism, genetic conditions, breastfeeding, family planning and breast and cervical health check information. The Department of Health and Social Services collaborates with the United Way agency in support of the 211 information systems for the state of Alaska. Specific calls regarding services delivered by agencies are not tracked.

In FY 2010 WCFH staff conducted Strengths, Weaknesses, Opportunities and Threats (SWOT) analyses with the Perinatal Advisory Committee, the Newborn Metabolic Screening Advisory Committee and the Early Hearing and Detection Intervention Advisory Committee. One consistent theme was that collaboration among stakeholders is very high. Another consistent theme was the usefulness and excellent quality of parent navigation services. WCFH has placed considerable effort in establishing advisory committees for all the MCH programs, including a teen advisory committee for the Adolescent Health program. Stakeholders are engaged on a regular basis throughout the year, both formally, via teleconferenced committee meetings, and informally, through emails and listservs. We have adopted the World Café model and SWOT analyses for soliciting input. Feedback from participants indicated that the World Café format worked well for them.

Late in FY 2009, parent support services were added as a program supervised by the Autism Program program manager. During FY 2010, the program manager worked with the Family Voices designee to establish a Family Advisory Committee representing families whose children experience chronic medical conditions or developmental disabilities. Most recently, the program manager has been traveling around the state assessing parent needs and service delivery gaps in the nine communities where Title V funded clinical services are offered. The information will be used to prioritize future program development.

The MCH-Epidemiology Unit published numerous reports, bulletins and peer-reviewed journal articles. The publications list is presented as an attachment, and are available at the MCH-Epidemiology website: http://www.epi.alaska.gov/mchepi/pubs/indexcategory.jsp

/2013/ The toll free hotline is still in existance, however the number of calls has decreased over time due to the influence of the internet, improvements in the quality and accuracy of information the state has on the web and the intential work to develop the 211 system in Alaska. //2013//

G. Technical Assistance

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	1111425	1111425	1102057		1091900	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	13657150	17352571	16744140		17372096	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	50000	100000	75000		100000	
7. Subtotal	14818575	18563996	17921197		18563996	
8. Other Federal Funds *(Line10, Form 2)*	4714559	4714559	6154100		6711300	
9. Total *(Line11, Form 2)*	19533134	23278555	24075297		25275296	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	1839809	1941404	1546640		1582408	
b. Infants < 1 year old	2265917	2630393	3307846		3193008	
c. Children 1 to 22 years old	1421506	2207975	3269509		3553745	
d. Children with	7560248	10503677	7965732		8521586	

Special Healthcare Needs						
e. Others	925441	451563	979004		868975	
f. Administration	805654	828984	852466		844274	
g. SUBTOTAL	14818575	18563996	17921197		18563996	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	93713		97300		65400	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		400000	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	3169602		3036100		3240200	
j. Education	0		0		0	
k. Home Visiting	0		0		1000000	
k. Other						
Family Planning	0		560700		576700	
Other HRSA, ACF, OAH	0		0		1429000	
HRSA and other	0		2460000		0	
HRSA-other funds	830136		0		0	
Title X-Family Plann	621108		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	1986923	2933304	2651286		3101638	
II. Enabling Services	4621808	5042980	5505336		5457047	
III. Population-Based Services	3171187	4171154	3576231		3490392	
IV. Infrastructure Building Services	5038657	6416558	6188344		6514919	
V. Federal-State Title V Block Grant Partnership Total	14818575	18563996	17921197		18563996	

A. Expenditures

/2011/Spending in FFY2009 was more than budgeted as a result of additional funds received for MCH programs
located in other divisions including behavioral health and the Women's, Infant and Children's Nutrition program.
Additional Medicaid funding was received in the Title V program to support school age children and outreach for

EPSDT as well as data analysis conducted by the MCH epidemiological staff for the Medicaid program. Additional
funding from the Mental Health Trust Authority was received to support expansion of the autism diagnostic clinics
and training in rural and remote communities. Two additional communities hosted screening clinics for children
suspected with autism or other neurodevelopmental disorders. Early screening and referral enabled these children
to be referred to the Providence Autism Diagnostic Network for a interdisciplinary diagnostic evaluation intensive
intervention services for children diagnosed with autism. Additional funding was recieved to support development of
formalized academic training paths leading to a occupational endorsement or degree in areas that support intensive
intervention for children diagnosed with autism. //2011//

/2012/ Spending in FY 2010 was increased for the original budgeted amounts as a result of an increase in federal grants and a slight increase in general funds for the Section of WCFH. Additional programs that support the MCH population received increases in state general funds including the early intervention/infant learning program.
Additional funding continued for WCFH in support of expanding the neurodevelopmental and autism screening
clinics, expansion of education and training for providers of intensive intervention services for children with autism spectrum disorder and other programs for children outside of WCFH. //2012//

/2013/
Additional federal grant were successfully awarded again this last year that will assist in system improvements in the areas of infant mortatlity and disaster/emergency planning for vulnerable and chronically ill populations. These funding streams will assist us in working on the priorities identified as a result of the 5 year MCH Needs Assessment. //2013//

B. Budget

/2011/ The budget for FFY2011 is anticipated to be slightly increased as a result of an increase in general funds from
the state in support of general infrastructure, autism workforce development and ongoing support of of the Alaska
birth defects and FASD surveillance systems. This later program is a statutorily required program which has relied
exclusively on MCH Title V Block grant funding for the last 5 years. Receipt of general funds dollars will assist in
shifting block grant funding to support programs for school health, school nursing and outreach of EPSDT screening.
Additional expenditures are budgeted for CYSHCN in support of transition to adulthood and expansion of specialty
clinics for screening of autism and neurodevelopmental disorders to 9 additional communities. The Title V program
consistently looks for ways to braid and blend funding for new and existing programs to assure an ongoing plan for
sustainability. A slight increase in federal funding for the Title V program is expected due to new and supplemental
grants applied for in the areas of Teen Pregnancy Prevention, Home Visiting and a Healthy Start Grant. //2011//

/2012/ The budget for FFY2012 will be stable in comparison to last year. There will be no

increase in state general funds anticipated and the amount of funding for federal grants is anticipated to be lower that that approved late in the federal fiscal year. This means that programs will expected to more with less funding particularly in with federal grants. There is continued reliance on program receipt income to fund many of the core services in the Section. Maintaining direct services only in areas that can not be supported in the private sector will continue for this year
including maintaining the expanded neurodevelopmental/autism clinics in rural Alaska. genetics, metabolic and cleft lip and palate clinics.
The Title V program continues
to look for ways to blend and braid staffing and funding to assure a maximum use. Three additional federal grants were received this last year with support of the state administration; however use of these funds has been put on hold pending further review from the Governor's office.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.